

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: _____



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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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AUTHORIZED PICK-UP LIST

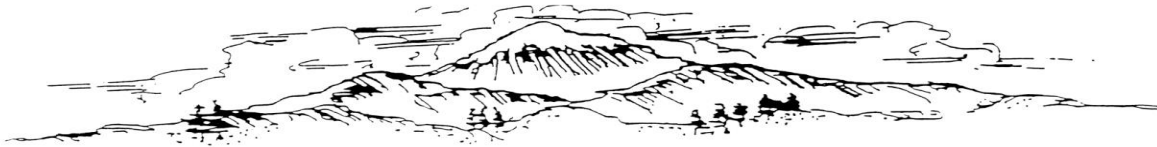
I hereby authorize the following people to pick up my child:

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



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SUNSCREEN

Children's House staff members will only be applying sunscreen to children during the summer months (June, July, & August) before we go outside for water activities or in special cases, such as a field trip, when we plan to be out in the sun for an extended period of time. Because this does not occur on a daily basis, parents are expected to apply sunscreen to their children's exposed skin as part of their morning routines at home year round. We will have sunscreen available in the bin room if parents forget and need to apply it at school. A sun hat is another good way of providing protection and can be kept in your child's bin as well. Please label the hat with your child's name if you choose to keep one here at school.

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

School Will Provide

A Children's House staff member has my permission to apply **NO-AD Children's Maximum Sun Block Lotion SPF 30** to my child before water activities and when prolonged sun exposure is anticipated.

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 apply it before water activities and when prolonged sun exposure is anticipated. 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

Parent Will Apply

It is not necessary for a staff member to apply sunscreen to my child under any circumstances, as I will do that before bringing my child to school.

Signature

Date



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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

Signature

Date



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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

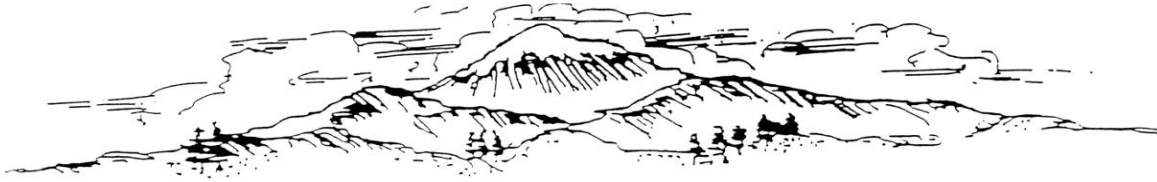
From time to time we take pictures during school activities. We would like your permission to use these pictures on our website, our school's Facebook page, in newsletters, and/or on our bulletin boards. We will never reference your child by name or provide any specific information regarding your child. 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



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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

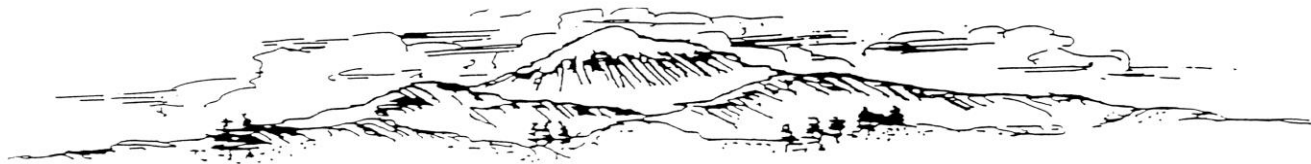
Date

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



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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.