

Little Blessings Student Information 2022-23

Student Name: *(full name and 'goes by')*

Gender:
M or F

Birthday: *(Month, Day, Year)*

Address: *(include street, city, state & zip)*
If child resides at 2 locations, include both addresses

Home phone: *(include area code)*

Church Affiliation (if any)

Guardian 1 Information:

Name:

Email Address

Cell phone:

Work phone:

Occupation:

Work Address:

Guardian 1 Information:

Name:

Email Address

Cell phone:

Work phone:

Occupation:

Work Address:

Emergency Contact:

(in the event the guardian cannot be reached)

Name:

Home/Work phone:

Cell phone:

Address:

Family Information:

Parents are: *(circle one)*

Married Divorced Separated Widowed Single

Student lives with: *(circle one)*

Parents Single Parent Foster Family Grandparents

Other (specify) _____

Siblings: *(Name, gender, age)*

First Enroll Date:

Office Use Only

Drop Date:

Schedule	Classroom	Email Lists	HeadMaster	Funding
M T W R F		MC G		
Full Half Combo				

Parent / Guardian Permission 2022-23

Please check yes or no and sign at the bottom

	YES	NO
I (Legal Guardian name) _____		
give permission for my child to ride a tricycle while on the playground.		
give permission for my child to be photographed for the website, newspaper, or social media.		
give permission for my child to use a cot or mat for napping.		
give permission for my child to view G-rated videos.		
give permission for my child to participate in hikes around and on Little Blessings' property.		
give permission for my child to come upstairs to the Fellowship Hall during inclement weather for large gross motor activity.		
give permission for my child to participate in activities associated with school functions such as the fall festival, holiday parties/events, end of year carnival (etc.) to include but not limited to: bounce house, hay rides, petting zoos, games, hunts, etc. I will check the web site for the scheduled activities. If I choose not to allow my child to participate in a particular activity, I will notify my child's teacher in writing.		
give permission for my child to play in or ride tricycles with his/her Little Blessings class on the paved, gated drive that is located between the building and the playground of the First United Methodist church.		
give permission for my child to enter the kitchen for special cooking activities.		

	Please initial
I (Legal Guardian name) _____	
understand that I must pre-pay 1/10th of the annual tuition upon acceptance into the program (or by May 1st, whichever is later). This amount will be applied as the August tuition, and I will prepay May tuition in August. I also understand that this amount is non-refundable or non-transferable should I leave the program.	
understand that my child will be photographed for internal use (ie student portfolios, classroom displays, gifts for guardians/parents, incident reports, teacher training/ evaluation etc)	
agree that if I receive CCAP, or any other tuition assistance, I will pay any tuition amount not covered by that assistance, each month and my parental fee no later than the last Friday of every month.	
will not hold the employees, agents, representatives or sponsors of Little Blessings liable for any injuries that may be incurred while attending Little Blessings or its sponsored events.	
understand that upon any changes in my child's medical or folder information, I will report it immediately to the Little Blessings' office.	
understand that I must update my child's medical forms and immunization records on a scheduled basis set by the Colorado Department of Human Services Office of Early Childhood. I also understand that if I do not supply Little Blessings with these records that my child will not be able to attend the program until the records are received or updated.	
will follow all responsibilities and procedures as outlined in the Parent Handbook.	
certify that all information provided in this folder is true and accurate.	
understand that upon leaving the program, I will have paid our account in full and put in writing our intention to leave the program.	

Guardian Signature

Date

Student Name:

Persons authorized to pick up child (Please exclude listed Guardians and Emergency Contacts):

Name:

Phone #:

Address:

City, State & Zip:

Name:

Phone #:

Address:

City, State & Zip:

Name:

Phone #:

Address:

City, State & Zip:

Name:

Phone #:

Address:

City, State & Zip:

Medical Information: I understand that I must provide the topical preparation in the original container labeled with

Allergies: *(Please indicate all allergies your child has. If none—write NONE.)*

Health conditions: *(Please indicate any health conditions your child may have that would affect his or her participation in school activities.)*

TOPICAL PREPARATIONS (PREVENTATIVE PERMISSION)

I understand that I must provide any the topical preparation (including but not limited to lip balms, lotions, ointments, diaper cream, etc) in the original container labeled with my child's full name and that no topical preparations will be applied to broken skin or if a skin reaction has been observed. It is my responsibility to check the ingredients to make sure my child is not allergic to it. Any skin reaction observed by staff will be reported promptly to the parent/guardian.

Parent/Guardian Signature: _____ Date: _____

Over the counter and prescribed topical ointments or drops

I agree to complete a topical permission slip to the teacher when sending any over the counter topical such as lip balms, lotions, diaper creams, and sunscreens. I agree to complete a medications form with the front office with a doctors signed note with any prescribed topical.

Parent/Guardian Signature: _____ Date: _____

Sunscreen

I give my permission for the staff at Little Blessings PDO to apply sunscreen to my child's exposed skin including the face, tops of ears, bare shoulders, arms, legs, and feet 30 minutes before outdoor activities. It is my responsibility to provide sunscreen with a minimum 15 SPF.

- ☐ In the event that my child does not have sunscreen with them, the school may apply **Equate 50 SPF** to my child.
☐ My child may NOT use any sunscreen other than the one that s/he brings.

Parent/Guardian Signature: _____ Date: _____

Medical Information:**Physician Information:**

Name:

Phone:**Address:****Dentist Information:**

Name:

Phone:**Address:**

Miscellaneous Information: *Please indicate below if your child has participated in any of the following and what month and year:*

___ Dental Screening ___/___

Hearing Screening ____/____

 Vision Screening /

Child Find _____ / _____

Hospital Information: Please indicate which hospitals you prefer in case of an emergency by checking the box.

Castle Rock Adventist
Health Campus
2350 Meadows Blvd
Castle Rock, CO
80109

Parker Adventist Hospital
9395 Crown Crest Blvd
Parker, CO 80138
303-269-4000

Sky Ridge Medical Center
1010 Ridge Gate Parkway
Lone Tree, CO
720-225-1000

Other: Name and Address

Correspondence Log (office use only)

[illegible]

Correspondence Log (office use only)

[illegible]