little red
SCHOOLHOUSE

Registration

Enrollment Date _____ Today's Date _____
Name _____ Age _____ Birthdate _____
PO Box _____ Town _____ State _____ Zip _____
Physical Address _____
Home Phone _____ Cell Phone _____

Parents/Guardians: (Please Circle) Together Divorced Separate
Mother _____ Cell Phone _____
Employer _____ Address _____ Phone _____
Email address _____
Father _____ Cell Phone _____
Employer _____ Address _____ Phone _____
Email address _____

Medical/Health Information *All Fields Required!

Child's Doctor* _____ Phone _____
Child's (Family's) Dentist* _____ Phone _____
Preferred Hospital* _____
Parent/Guardian Signature _____ Date _____

Parent Release and Insurance

Child's Name _____ Date _____

I, _____ give my permission to the Little Red Schoolhouse to call and authorize any certified physician or medical staff to provide medical or surgical care for my above named child should any emergency arise. It is understood that a conscious effort will be made to locate us. All expenses incurred will be accepted by us.

Our insurance carrier is _____

Group/ Policy Number _____

Signature _____ Date _____

Updated 10/2016

little red
SCHOOLHOUSE

Emergency Contact and Pick Up

I authorize the below listed adults to assume responsibility for my child in the case of my absence and/or in the case I cannot be reached in an emergency:

Child's Name _____ Date_____

Name _____ Relationship _____

Work/Cell Phone _____ Home Phone _____

Name _____ Relationship _____

Work/Cell Phone _____ Home Phone _____

Please make sure the responsible adult picking up your child has identification to prove they are authorized to pick up your child.

Little red
SCHOOLHOUSE

2019 Parent Contract/ Handbook Acknowledgement

All parents must read and sign this contract

I hereby agree to comply with the rules and regulations of Little Red Schoolhouse specified in the Parent's Handbook issued by the school each year.

I am aware of the scheduled school holidays that Little Red Schoolhouse is closed.

I understand that my child's file shall be kept up to date at all times. If requested updates are not submitted in a timely manner, my child may not be able to attend until their file is complete with all necessary updates, medical forms and other necessary paperwork.

I hereby agree to notify the school two weeks in advanced of permanent withdrawal, should such event occur, or pay the difference.

I understand that I will be required to volunteer 1 hour per month, or contribute to the classroom wish list, otherwise I will be charged $40 per month. Wish list items contributed must be written in the volunteer book.

Bills for child care will be distributed before the first of each month. Payments will be made directly to the center for child care services and are due no later than the 5th of each month. Outstanding balances will be subject to an additional $50 charge on the 15th of each month that the balance is unpaid.

Children should arrive by 9:30 am. A schedule is set for your child and it is the responsibility of the parents to cancel no later than 9:00 am if you will be unable to attend. This is so we have ample time to fill the day with a drop-in or rearrange staffing if needed. We appreciate your cooperation with this. There will be no reimbursement for absent days. **Drop-in days are based upon availability on a given day and are $50 cash or check, due the morning of.**

Little Red Schoolhouse agrees to update parents in writing of any changes in these policies.

I have read and understand the above statements, as well as the entire Parent Handbook, and will comply with the rules and regulations of Little Red Schoolhouse.

Signed _____ Date _____
Mother or legal guardian

Signed _____ Date _____
Father or legal guardian

little red
SCHOOLHOUSE

Program Consent

I, the parent/guardian of _____ (hereby to be future referred to as" the child" or "my child"), grant permission for my child to participate in all LRSH, Inc. activities including but not limited to swimming and other outdoor and indoor activities and functions. I recognize, for myself and the child that these activities involve inherent risks of injury and my child may be subject to serious or fatal injury by participating in these activities. I am enrolling my child with knowledge of these and other risks and expressly agree to assume them on behalf of the child.

Further, I consent to and authorize the use and reproduction for any purpose and without compensation, of all photographs of my child and any of my child's art and for my child to be included in evaluations, screenings and assessments.

I grant permission for my child to ride the Breckenridge Free Ride, Summit Stage, and Breckenridge Gondola. I also agree to allow my child to be transported by private vehicle with the understanding that I will provide an appropriate car seat to be used in private vehicles only. I recognize, for myself and the child, that use of these forms of transportation involve inherent risks and that my child may be subject to serious or fatal injury and I expressly agree to assume such risks on behalf of the child and myself.

I authorize LRSH, Inc., at the discretion of any supervising employee, to obtain any reasonably necessary medical care for my child and/or to transport or arrange transport for my child to the appropriate clinic or hospital if medical attention appears to be necessary. I understand that LRSH, Inc. will attempt to locate me in the event of such an emergency. But if it is not possible to locate me, I further authorize a licensed physician, dentist or other medical care provider to carry out any emergency medical care of my child. I agree to pay all costs associated with such medical treatment and related transportation for my child.

I further authorize LRSH, Inc. employees to apply sunscreen with an SPF of 15 or higher to my child for the purpose of UV protection. I give permission for my child to view age appropriate videos.

I hereby agree to forever release, indemnify and hold harmless LRSH Inc, its owners, directors, and staff from any loss of toys, clothing or personal articles resulting from my child's participation in school activities.

I authorize LRSH, Inc. to utilize the online child management system of Early Learning Ventures Alliance or "CORE" at Early Childhood Options to manage my child's health, enrollment information and security codes.

Next Page ⟶

Program Consent (continued)

I hereby agree to forever release, indemnify and hold harmless LRSH Inc, its owners, directors, employees, independent contractors and staff from any and all claims, causes of action, liabilities including but not limited to negligence, breach of warranty, expressed or implied, expenses (including attorney d\fees), that may arise as a result of placement of my child in the programs provided by LRSH Inc, including but not limited top any injury, fatal injury, damage or loss which my child may sustain or cause or to which my child may contribute to any other child enrolled in the programs provided by LRSH Inc.

I hereby warrant to LRSH Inc. that I am entitled to legal custody and possession of my child and accordingly am authorized to place my child in your care and custody and am further authorized to sign this enrollment and authorization form.

Signature of Parent/Guardian _____ Date _____

Signature of Parent/Guardian _____ Date _____

little red
SCHOOLHOUSE

Health Guidelines for Child Care and Schools

Karen Wyatt, M.D., Summit County Public Health Officer
Summit County Child Care Licensing
Summit County Public Health Nursing

Our goal is to provide a healthy environment for children. To achieve this goal, cooperation is needed by child care providers, schools and parents. The following recommendations are guidelines and individual variations should be considered on a case by case basis.

1. A child with a fever over 100 under the arm should not attend school. An infant under 4 months with a fever over 99 under the arm should not attend school. The child may return after he/ she has been **without a fever for 24 hours, without fever-reducing medication.**
2. The attending personnel should evaluate a child with green or yellow nasal discharge. If the child is lethargic, unwilling to play or not taking fluids, the child should not attend school. The parents may need to seek medical advice.
3. A child with a severe or croupy cough should not be in school, seek medical advice.
4. A child with Pink Eye should not return to school until 24 hours after the start of medication.
5. A child with Strep (streptococcal infection) may not return until he/ she has been taking antibiotics for 24 hours.
6. A child should not be allowed in school if he/ she has two or more watery stools in one day. The child may return after he/ she has not had diarrhea for at least 24 hours, and has solid stools. Parents should seek medical advice.
7. A child who is inconsolably fussy should not be in school. Parents may see medical advice.
8. A child who is vomiting should not be in school. The child may return after he/ she has not vomited for at least 24 hours. Parents may seek medical advice.
9. If a child has infected skin with crusts and/ or drainage, a physician must evaluate the condition before returning.
10. Any child with a contagious skin rash may not return until the rash has disappeared.
11. When a child in care has been diagnosed with a communicable illness including hepatitis, measles, mumps, meningitis, diphtheria, rubella, salmonella, giardia, tuberculosis, and shigella; the caregiver must immediately notify the parents or guardians of all children in care and report to the local public health office or the Colorado Department of Public Health and Environment. A diagnosed child must be excluded from care for the period of time prescribed by the child's physician or by the local public health office. Furthermore, a child that has not been immunized against the illnesses mentioned above, will not be able to attend school for a designated period of time, as recommended by a health care professional.

Parent Signature_____ Date_____

Updated 02/19

General Health Appraisal Form

Parent: *Please complete*

Child's Name: _____ **Birthdate:** _____

Allergies: ❑ None ❑ Describe: _____

Type of Reaction: _____

Diet: ❑ Breast Fed ❑ Formula: _____ ❑ Age Appropriate

❑ Special Diet: _____

❑ **Preventive creams/ointments/sunscreen** may be applied as requested in writing by parent, unless skin is broken or bleeding.

Sleep: Your health care provider recommends all infants less than 1 year of age be placed on their back for sleep.

I, _____ give consent for my child's health provider, school or camp personnel to discuss my child's health concerns. My child's health provider may fax this form (and applicable attachments) to my child's childcare provider, school, or camp. FAX Number: 970-453-6501 Little Red Schoolhouse

_____ Date: _____

Parent or Legal Guardian Signature — Authorization expires 365 days after this date

Health Care Provider: *Please complete after parent section has been completed*

Date of Last Exam: _____ **Recent Weight:** _____ ****HCT:** _____ **** B/P:** _____ ****Lead Level:** _____

Physical Exam: ❑ Normal ❑ Abnormal *(see explanation of significant health concerns:)*

Significant Health Concerns: ❑ None ❑ Reactive Airways Disease ❑ Seizures ❑ Diabetes ❑ Developmental Delays ❑ Vision ❑ Hearing ❑ Hospitalizations ❑ Severe Allergies ❑ Other *(dental, nutrition, behavior, etc.)* _____

Explain above concerns (if necessary, include instructions to childcare providers): _____

_____

Current Medications/Special Diet: ❑ None ❑ Describe: _____

_____

(Separate medication authorization form required for medications given in Child Care)

Fever reducer or pain reliever ***(mark only one product: max. 3 consecutive days without additional medical authorization)***

❑ Acetaminophen (Tylenol®) may be given for pain or fever over 102° every 4 hours as needed:
Dose _____ ❑ See attached Dosage Schedule from our office

OR

❑ Ibuprofen (Motrin®, Advil®) may be given for pain or fever over 102° every 6 hours as needed:
Dose _____ ❑ See attached Dosage Schedule from our office

Immunizations: ❑ Up-to-date ❑ See attached immunization record ❑ Administered today: _____

_____

Signature:

Next Well Visit: ❑ Per AAP Guidelines* or ❑ Age: _____

This child is healthy and may participate in all routine activities, sports, camps, and child care. Any concerns or exceptions are identified on this form.

_____ _____

Signature of Health Care Provider (certifying form was reviewed) — Date

Office Stamp: *Or write Name, Address, Phone Number*

The Colorado Chapter of the American Academy of Pediatrics (AAP), Healthy Child Care Colorado, and Headstart have approved this form 04/04.

* The AAP recommends that children from 0-12 years have health appraisal visits at: 2, 4, 6, 9, 12, 15, 18 and 24 months, and age 3, 4, 5, 6, 8, 10 and 12 years.

** Required by Head Start programs only per state EPSDT schedule

little red
SCHOOLHOUSE

Infant & Toddler Questionnaire

Name:_____ DOB:_____ First Day of School:_____

Eating

What is your child's eating pattern? How much? (Bottle feeding, number of ounces, solids, rice cereal)

AM_____ PM_____

_____ _____

_____ _____

Bottles

Is your child breast or bottle-fed? _____

If formula, what type? _____

What temperature does your child prefer his/her bottle?

Cold _____ Warm _____ Very Warm _____

When does your child need to be burped? Mid Bottle After Bottle Not at All

Are there any feeding concerns we should know about? _____

_____

Solids

If your child eats cereal, how is it prepared? (ex: warm, thick) _____

What other solid food has your child experienced? _____

_____

Sleeping

What is your child's sleep schedule?

Nighttime from _____ to _____

AM Nap from _____ to _____

PM Nap from _____ to _____

Do you have a specific way of helping your child fall asleep? A special routine?

How does your child show he or she is tired?

Does your child have a special blanket, lovie, toy or pacifier that he or she sleeps with?

***In order to comply with Licensing Rules and Regulations, infants under 12 months are only permitted to sleep with a sleep sack and/or pacifier in their crib during sleep** Additional items are only permitted with a doctor's note on file.*

little red
SCHOOLHOUSE

Infant & Toddler Questionnaire continued

Name: _____

Does your child use a pacifier? What are your guidelines about using it?

Is your child fairly regular in his or her sleeping habits? If he or she experiences sleeping difficulties, how do you handle them?

Diapering & Toileting

How frequently does your child have a BM?
What is the typical appearance of the BM?

What words (if any) does your child use for…

- Urination _____
- Bowel movements _____
- Pacifier _____
- Bottle _____
- Lovie _____
- Body parts _____

Is your child in the process of toilet training? If so, how can we assist with this process?

Feelings & Emotions

How does your child like to be comforted?

Are there things that scare your child (ex: dogs, new faces or loud noises)?

How does he or she express anger or frustration?

How does he or she express feelings of pleasure, excitement or joy?

What do you do when your child does something you think is wrong, or not listening to you?

What are your child's interests? What does he or she like to do?

In a few sentences, how would you describe your child?

Is there any other special information that we should know to better serve your child?

little red
SCHOOLHOUSE

Health & Social Information
Health History

Child's Name_____ Date_____

Does your child seem well most of the time? Yes No
Is your child taking any medication at this time? Yes No
If yes, which medication? _____
Why? _____
Known Allergies (food, drugs, other)_____
Does your child have an Epi-Pen? If yes, under what circumstances should it be used?
_____
Has your child had any operations or been hospitalized? Yes No
Please describe _____
Any illnesses, medical conditions or special needs? Yes No
Please describe:_____
Has your child had any serious accidents or poisoning? _____
Does your child have any physical disabilities? _____
Is your child under the care of a physician? If yes, please explain: _____
_____
Any behavioral issues we should know about? _____
_____
Any history of:
Convulsions/seizures:Yes___ No___ Head Injury: Yes___ No__
High Fevers (over 103): Yes___ No___ Asthma: Yes___ No__
Diabetes in the family: Yes___ No___ Heart Trouble:Yes___ No__
Premature Birth: Yes___ No___ Birth Injury: Yes___ No__
If so, how early?_____
Does your child have any distinguishing marks such as scars, moles or birthmarks?
Please describe. _____
Are you concerned about your child's vision? Yes_____ No_____
Are you concerned about your child's hearing? Yes_____ No_____
Does your child have more than 3 colds or sore throats with a fever in a year? Yes No

little red
SCHOOLHOUSE

Social Information

Child's Name_____ Date_____

Who has cared for your child other than the parents? _____

List other children in your family:

Name Age Sex

_____

_____

Favorite toys, activities _____

_____

_____

_____

Please give any information that may help us make your child's school experience a great one! (play, eating and sleeping habits, fears, likes, dislikes, etc.): _____

_____

_____

_____

_____

_____

_____

_____

_____

Describe your developmental goals for your child this school year (ex. becomes more social, experience cause and effect, spell their name, etc.):

_____

_____

_____

_____

_____

_____

Child Name:_____

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS)

Company Name LRSH Inc. (dba Little Red Schoolhouse) Company ID Number _____

I (we) hereby authorize LRSH Inc. , hereinafter called COMPANY, to initiate debit entries to my (our) ☐ Checking Account / ☐ Savings Account (select one) indicated below at the depository financial institution named below, hereafter called DEPOSITORY, and to debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Depository Name _____ Branch _____

City _____ State _____ Zip _____

Routing Number _____ Account Number _____

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Name(s) _____ ID Number _____
(Please Print)

Date _____ Signature _____

NOTE: WRITTEN DEBIT AUTHORIZATIONS MUST PROVIDE THAT THE RECEIVER MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR IN THE MANNER SPECIFIED IN THE AUTHORIZATION.

Amount to be withdrawn will be monthly tuition fee. Payment for any volunteer fees, drop-in days, late pick-up fees or other will need to be arranged separately.

Draw date will be on the 5th of the month or the next following business day if the 5th falls on a non-banking day.

No fees associated with this service will be charged.

Families with multiple children, please complete a separate ACH form for each child.