Colorado Child Care Registration Form

Date of Enrollment: _____

Child's Name: _____Nickname: _____

Home Address: _____

Home Phone: _____ Sex: M F Age: _____ Date of Birth: _____

Family Members: _____

Mother or Guardian's Name: _____

Address if different from child's: _____

Zip: _____ Home Phone: _____ Cell Phone: _____Email: _____

Name of Employment (Mother/Guardian): _____

Address of Employment: _____ Work Phone: _____

Father or Guardian's Name: _____

Address if different from child's: _____

Zip: _____ Home Phone: _____ Cell Phone: _____Email: _____

Name of Employment (Father/Guardian): _____

Address of Employment: _____ Work Phone: _____

Special instructions for reaching parent or guardian: _____

Emergency Contacts:

1. Name: _____ Home Phone: _____

Address: _____

Work Phone: _____ Relationship to child: _____

2. Name: _____ Home Phone: _____

Address: _____

Work Phone: _____ Relationship to child: _____

Child Pickup Information

Persons Authorized to pick up your child
(Must show photo ID)

Name: _____

Home Phone: _____ Work Phone: _____

Name: _____

Home Phone: _____ Work Phone: _____

Name: _____

Home Phone: _____ Work Phone: _____

Name, address and phone number of child's doctor: _____

_____

Name, address and phone number of child's dentist: _____

_____

Hospital of Preference (Please check one): ☐ The Children's Hospital
13123 East 16th Ave
Aurora, CO 80045
720-777-1234

☐ Denver Health Emergency Department
777 Bannock St Pavilion A,
Denver, CO 80204
303-436-6000

☐ Other _____
_____
_____

Chronic Medical Conditions: _____

Does your child have a health care plan? _____

*If yes, the health care plan must be provided on or before the first day the child is in care.

Is your child fully immunized? _____

*Complete immunization records must be provided on or before the first day the child is in care.

Health History

(Chronic or Recurring)

Ear Infections: _____

Diabetes: _____

Heart disease/defect: _____

Convulsions/seizures: _____

Asthma: _____

Nosebleeds: _____

Measles: _____

Mumps: _____

Chicken Pox: _____

Flu or Flu Shot: _____

Allergies

(Nature of Reaction)

Hay Fever: _____

Plant Poisoning: _____

Insect Stings: _____

Penicillin: _____

Other drugs: _____

Animals: _____

Food: _____

Other: _____

Operations or serious injuries (dates): _____

Is the child on any medications? (Explain): _____

If yes, please describe: _____

Physical Limitations: _____ Describe if yes: _____

Dietary Limitations: _____ Describe if yes: _____

Vision: _____ Hearing: _____

Are there any activities that you prefer that your child **NOT** participate in?

If so, please list: _____

I hereby give permission to _____ to call a doctor or emergency medical services and for the doctor, hospital or medical service to provide emergency medical or surgical care for my child, _____.

It is understood that the childcare provider will make a conscientious effort to locate the parent/guardians and emergency contacts listed on the registration document before any action will be taken. If it is not possible to locate emergency contacts listed treatment will not be delayed. I/we will accept the expense of any emergency transportation, medical or surgical treatment.

Parent/Guardian Signatures:

_____ Date: _____

_____ Date: _____

COLORADO CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com

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 ACIP schedule. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at 6th grade entry.

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

Parent/guardian: .....

Required Vaccines

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

*A positive laboratory titer report must be provided to the school to document immunity.

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

Recommended Vaccines

	Immunization date(s) MM/DD/YY						
HPV Human Papillomavirus							
Rota Rotavirus							
MCV4/MPSV4 Meningococcal							
Men B Meningococcal							
Hep A Hepatitis A							
Flu Influenza							
COVID-19							
Other							

Health care provider Signature or Stamp: _____ Date: _____

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

OR

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: _____