Colorado Child Care Registration Form

	Date of Enr	ollment:
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:		
		Email:
Name of Employment (Father/Guardian):		
Address of Employment:		Work Phone:
Special instructions for reaching parent or	guardian:	
	Emergency Contac	cts:
1. Name:		Home Phone:
Address:		
		child:
2. Name:		Home Phone:
Address:		
	Relationship to o	

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 numb	er of child's doctor:	
Name, address and phone numb	er of child's dentist:	
Hospital of Preference (Please ch	eck 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 ca	e plan?	
*If yes, the health care plan mus	be provided on or before the first day the child is in care.	
Is your child fully immunized?		

 $[\]hbox{*Complete immunization records must be provided on or before the first day the child is in care.}\\$

Health History (Chronic or Recurring)	Allergies (Nature of Reaction)
Ear Infections:	Hay Fever:
Diabetes:	Plant Poisoning:
Heart disease/defect:	Insect Stings:
Convulsions/seizures:	Penicillin:
Asthma:	Other drugs:
Nosebleeds:	Animals:
Measles:	Food:
Mumps:	Other:
Chicken Pox:	
Flu or Flu Shot:	
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 p	orefer that your child NOT participate in?
If so, please list:	
	a doctor or emergency medical services and for the doctor, lical or surgical care for my child,
emergency contacts listed on the registration docume	a conscientious effort to locate the parent/guardians and ent before any action will be taken. If it is not possible to e delayed. I/we will accept the expense of any emergency
Parent/Guardian Signatures:	
	Date:
	Date:

COLORADO CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com



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.

Parent/guardian: Required Vaccines		
pp B Hepatitis B TaP Diphtheria, Tetanus, Pertussis (pediatric) dap Tetanus, Diphtheria, Pertussis d Tetanus, Diphtheria, Pertussis d Tetanus, Diphtheria ib Homophilus influenzoe type b W/OPV Polus CV Pneumococcal Conjugate MR Measles, Mumps, Rubella easles umps ubella arricella Chickenpox Varicella - positive screen date Varicella - positive screen date Varicella - positive screen is not acceptable proof of immunity to RECOMMENDED PV Human Papillomavirus PV Human Papillomavirus PV Human Papillomavirus Data Rotavirus CV4/MPSY4 Meningococcal en B Meningococcal en B Meningococcal u influenza OVID-19 ther Date:		
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tudent is current on required immunizations for age (circle one):		
R nmunization record transcribed/reviewed by school health authority:		
chool 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 age colorado Immunization Information System, the state's secure, confidential immunization registry.		
Parent/Guardian/Student (emancipated or over 18 yrs old) signature: Date:	ncies and tr	