

On or before your child's first day of attendance we will need:

\_\_\_ Enrollment Application

\_\_\_ Completed emergency contact information form

\_\_\_ Financial Agreement and Payment Policy/Family Handbook Agreement

Form (signed by both parents if applicable)

\_\_\_ Signed Permission Forms

\_\_\_ General Health Appraisal Form signed by physician

\_\_\_ Current records of immunization

\_\_\_ Allergy, Asthma, and Special Health Conditions, if required

\_\_\_ Health Care Plan, if required

\_\_\_ Door Access Badge completed and turned into Susan

Your \$50.00 registration fee and tuition for the first month/remainder of the month, paid by credit card on the website:

<https://commerce.cashnet.com/rrcccdcpay>

**APPLICATION FOR ENROLLMENT**

Date of Enrollment \_\_\_\_\_ Date of termination \_\_\_\_\_

Child's Name \_\_\_\_\_ Nickname \_\_\_\_\_

Birth Date \_\_\_\_\_ Place of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Phone \_\_\_\_\_ Child lives with \_\_\_\_\_

Relationship to child \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Does your child have medical insurance? \_\_\_\_\_ Documented vision screening? \_\_\_\_\_ Documented hearing screening? \_\_\_\_\_ Documented dental screening? \_\_\_\_\_ Do you need resources on how to obtain medical insurance? \_\_\_\_\_

Name and phone of child's primary care provider \_\_\_\_\_

Family Member #1 \_\_\_\_\_ Relationship to child \_\_\_\_\_

\_\_\_Parent\_\_\_ Step Parent\_\_\_ Legal Guardian\_\_\_ Temporary

Guardian\_\_\_ Other\_\_\_ Joint Custody\_\_\_ Not Joint Custody

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cellular \_\_\_\_\_

Pager \_\_\_\_\_ email \_\_\_\_\_

Social Security # \_\_\_\_\_ Driver's license # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_

If we cannot immediately contact you at work, who could find you:

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Family Member #2 \_\_\_\_\_ Relationship to Child \_\_\_\_\_

\_\_\_Parent\_\_\_ Step Parent\_\_\_ Legal Guardian\_\_\_ Temporary

Guardian\_\_\_ Other\_\_\_ Joint Custody\_\_\_ Not Joint Custody

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Pager \_\_\_\_\_ email \_\_\_\_\_

Social Security # \_\_\_\_\_ Drivers License # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_

If we cannot immediately contact you at work, who could find you:

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Are there legal restrictions on who can have contact with your child? \_\_\_No

\_\_\_Yes

If yes, please list and submit legal papers.

Persons Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Photo on file? \_\_\_No \_\_\_Yes

Other's living in home:

First & Last Names \_\_\_\_\_ Age \_\_\_\_\_ Relationship to child \_\_\_\_\_

First & Last Names \_\_\_\_\_ Age \_\_\_ Relationship to child \_\_\_\_\_  
First & Last Names \_\_\_\_\_ Age \_\_\_ Relationship to child \_\_\_\_\_  
First & Last Names \_\_\_\_\_ Age \_\_\_ Relationship to child \_\_\_\_\_  
Ethnic Information for use in writing grant proposals:

What language is spoken in the home? \_\_\_\_\_

Check one: \_\_\_ Alaskan Native/American Indian \_\_\_ Asian/Pacific  
Islander \_\_\_ Black, not Hispanic \_\_\_ Hispanic \_\_\_ White

People who may be called in an emergency and who are authorized to take your child from our Center. We cannot release your child to anyone NOT on the list, other than parents/guardians. Please indicate who to call first in an emergency.

Name #1 \_\_\_\_\_ Relationship to Child \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_

Name #2 \_\_\_\_\_ Relationship to Child \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_

Name # 3 \_\_\_\_\_ Relationship to child \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_

Health Care Practitioner Name \_\_\_\_\_ Phone \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone \_\_\_\_\_

Preferred hospital \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

We understand it is our responsibility to inform the Children's Center @ Red Rocks Community College any time the above information changes. We also understand that the center will attempt to reach one of the people on this form, trying to reach us as parents/guardians first, if there is an emergency, before any action is taken. In the event that we cannot be reached, the staff has our permission to use discretion in securing medical aid. We give permission for emergency medical or hospital personnel to perform the necessary care needed for our child during an emergency. We further understand that the Children's Center @ RRCC, the staff at the Children's Center @RRCC, Red Rocks Community College, the staff at Red Rocks Community College and/or any person responsible for obtaining medical aid for our child will not be responsible for any expense incurred by our family due to medical aid being given to our child.

Parent/Guardian #1 Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent/Guardian #2 Signature \_\_\_\_\_

Date \_\_\_\_\_

**A \$50.00 non-refundable registration fee is due with this application.**

**CHILDREN'S CENTER @RED ROCKS --EMERGENCY INFORMATION**

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Legal Guardian # 1 Name: \_\_\_\_\_

Telephone Numbers: Home \_\_\_\_\_ Work \_\_\_\_\_

Legal Guardian #2 Name: \_\_\_\_\_

Telephone Number Home: \_\_\_\_\_ Work \_\_\_\_\_

**Emergency Contacts (to whom child may be released if legal guardian is unavailable)**

Name # 1 \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Numbers: Home \_\_\_\_\_ Work \_\_\_\_\_

Name # 2 \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Numbers: Home \_\_\_\_\_ Work \_\_\_\_\_

**Child's Usual Source of Medical Care**

Name \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number \_\_\_\_\_

**Child's Usual Source of Dental Care**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number \_\_\_\_\_

**Child's Health Insurance**

Name of Insurance Plan: \_\_\_\_\_ ID # \_\_\_\_\_

Subscriber's Name (on insurance card): \_\_\_\_\_

**Special Conditions, Disabilities, Allergies, or Medical Information for Emergency Situations**

\_\_\_\_\_

\_\_\_\_\_

**Transport Arrangements in an Emergency Situation**

Ambulance service \_\_\_\_\_ Child will be taken to: \_\_\_\_\_  
(Parents/guardians are responsible for all emergency transportation charges)

**Parents/Legal Guardian Consent and Agreement for Emergencies**

As parent/legal guardian, I give consent to have my child receive first aid by facility staff, and if necessary, be transported to receive emergency care. I understand that I will be responsible for all charges not covered by insurance. I give consent for the emergency contact person listed to **act on my behalf** until I am available I agree to review and update this information whenever a change occurs and at least every 6 months.

Date: \_\_\_\_\_ Parent/Legal Guardian's Signature # 1 \_\_\_\_\_

Date: \_\_\_\_\_ Parent/Legal Guardian's Signature #2 \_\_\_\_\_

## FAMILY HANDBOOK AGREEMENT

I HAVE READ AND UNDERSTAND THAT OUR FAMILY WILL FOLLOW THE PRACTICES AND POLICIES SET FORTH IN THE MOST CURRENT FAMILY HANDBOOK FOR THE CHILDREN'S CENTER AT RED ROCKS COMMUNITY COLLEGE. I KNOW IF I HAVE QUESTIONS THAT I AM TO CONTACT THE DIRECTOR OF THE CENTER FOR ANSWERS TO MY QUESTIONS.

Parent/Guardian #1 \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian #2 \_\_\_\_\_ Date \_\_\_\_\_

### FINANCIAL AGREEMENT AND PAYMENT POLICIES

- **Payment is due for the month of care of the first of each month. A late fee of \$25.00 will be assessed on the 10<sup>th</sup> of the month if tuition has not been paid.**
- **Check:** Make checks payable to The Children's Center.
- **Credit Card:** All credit card payments (preferred method) are made on line at <https://commerce.cashnet.com/rcccdcpay>. Responsible party must log in **the first attendance day of each month to make payment.**
- **Cash:** Cash payment must be made at college cashiers dept. Please pick up a Miscellaneous Deposit Form to take with your payment.
- Tuition is based on contracted days, not on actual days of attendance.
- **Payment is due for enrolled days whether child attends or not. We cannot substitute attendance days if your child does not attend on his/her scheduled days of attendance.**
- There is a non-refundable \$50.00 registration fee per child due at time of registration and each August. A portion of this fee pays for the on line assessment program used to track each child's development. Families who enroll after May 31 will not be charged the annual fee until the following year.
- Holidays and in-service days are fee days. Families are not charged for 1 week of closure in Aug. and 1 week of closure in Dec. Tuition is calculated multiplying weekly rate x 50 weeks /12 months and rate is consistent each month.
- Childcare may be denied for any child for whom tuition is more than 2 weeks late.
- Accounts are subject to a \$25.00 processing fee for returned check or denied card.
- Late pick up fee is \$1.00 per minute after 6pm. Consideration is made for weather conditions and circumstances.
- Vacations-full payment is due for 2 consecutive weeks of vacation, and 50% for additional consecutive weeks, if written notice of vacation is provided.
- Parent fees for families receiving CCCAP assistance must be paid in full on the first attendance day of each month.

I understand the monthly fee for my child is \_\_\_\_\_ and I have read and agree to the financial policies outlined in the Family Handbook and above.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

# The Children's Center @ RRCC Permission Requests

## Topical Preparations (Preventive)

Please check all of the permissions that you agree to. If you do not wish to grant permission for any of the permissions below, please indicate NO and discuss with the director.

Child's Name \_\_\_\_\_

**Sunscreen:** I give permission for the staff of The Children's Center @ RRCC to apply sunscreen to my child's exposed skin. I understand that it is my responsibility to apply sunscreen to my child in the morning prior to or upon arrival. The staff will reapply sunscreen in the afternoon.

\_\_\_\_\_ I will provide sunscreen for my child, labeled with first and last name on the container, as well as the noted expiration date and I will replace prior to expiration.

\_\_\_\_\_ I authorize the use of Think Baby, Mineral Sunscreen SPF 50 on my child.

## Lotion/Lip Balm

\_\_\_\_\_ I will provide a fragrance-free lotion and/or lip balm, labeled with my child's first and last name on the container, as well as the noted expiration date and I will replace prior to expiration.

\_\_\_\_\_ I authorize the staff to use fragrance-free moisturizing lotion on my child.

## Diaper Ointment/Cream

\_\_\_\_\_ I authorize the staff of The Children's Center @ RRCC to apply diaper rash ointment/cream to my child, in the original container, labeled with my child's full name and with the noted expiration date and I will replace prior to expiration. I understand that I may only provide diaper rash ointment/cream, free of antibiotic, antifungal or anti-inflammatory components **without a written prescription from my doctor.**

I agree to the use of the products mentioned above and understand that I must check the ingredients of all products to ensure that my child is not allergic to them. I understand that skin lotion/cream/balm will not be applied to broken skin or if a skin reaction has been observed. Parent will be informed of skin reaction promptly.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

## The Children's Center @ RRCC Permission Requests

Child's Name \_\_\_\_\_

**College students working with children** The Children's Center is a lab site for students. Students may do observations and activities with children in The Children's Center for educational/training purposes. These students have completed background checks and are always supervised by staff.

\_\_\_\_\_ I give permission for my child to be observed and participate in activities with the Early Childhood Education students at the college.

**Photo/Video Use** Photos/videos taken of children in the classroom are often appropriate for staff and training in Early Childhood Education classes, as well as other classes such as Psychology. Videos and photos will never be used for commercial purposes.

\_\_\_\_\_ I give permission for my child's picture to be used for the above purposes.

**Walks on college campus** Children may take walks with the staff on the college campus, both indoors and out. If children were to cross streets, the walk would be considered a field trip and a special permission form would be requested, prior to the walk.

\_\_\_\_\_ I give permission for my child to take walks with the staff on college campus indoors and outdoors.

**Media Use** On rare occasions, a teacher may select a video to enhance topics that the children are investigating.

\_\_\_\_\_ I give permission for the staff to use video to enhance a topic the children are learning about.

**Use of Cots For Rest** Permission must be granted for children under the age of two to rest on a cot.

\_\_\_\_\_ I give permission for my child to lay on a cot during rest time.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

# GENERAL HEALTH APPRAISAL FORM

**PARENT please complete AND SIGN**

**Child's Name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

**Allergies:**  None or Describe \_\_\_\_\_  
Type of Reaction \_\_\_\_\_

**Diet:**  Breast Fed  Formula \_\_\_\_\_  Age Appropriate  
 Special Diet \_\_\_\_\_

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

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

I, \_\_\_\_\_ give consent for my child's care health provider, school child care or camp personnel to discuss my child's health concerns. My child's health provider may fax this form (& applicable attachments) to my child's school, child care or camp personnel. FAX #: \_\_\_\_\_ DATE: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

**HEALTH CARE PROVIDER: Please Complete After Parent Section Completed**

**Date of Last Health Appraisal:** \_\_\_\_\_ **Weight @ Exam:** \_\_\_\_\_

**Physical Exam:**  Normal  Abnormal (Specify any physical abnormalities) \_\_\_\_\_

**Allergies:**  None or Describe \_\_\_\_\_ Type of Reaction \_\_\_\_\_

**Significant Health Concerns:**  Severe Allergies  Reactive Airway Disease  Asthma  Seizures  Diabetes  Hospitalizations  
 Developmental Delays  Behavior Concerns  Vision  Hearing  Dental  Nutrition  Other \_\_\_\_\_

Explain above concern (if necessary, include instructions to care providers): \_\_\_\_\_

**Current Medications/Special Diet:**  None or Describe \_\_\_\_\_

Separate medication authorization form is required for medications given in school, child care or camp

**For Fever Reducer or Pain Reliever (for 3 consecutive days without additional medical authorization) PLEASE CHOOSE ONE PRODUCT**

Acetaminophen (Tylenol) may be given for pain or fever over 102 degrees every 4 hours as needed

Dose \_\_\_\_\_ or see the attached age-appropriate dosage schedule from our office

**OR**  Ibuprofen (Motrin, Advil) may be given for pain or for fever over 102 degrees every 6 hours as needed

Dose \_\_\_\_\_ or see the attached age-appropriate dosage schedule from our office

**Immunizations:**  Up-to-Date  See attached immunization record  Administered today: \_\_\_\_\_

**Health Care Provider: Complete if Appropriate**

**\*\*ONLY REQUIRED BY EARLY HEAD START AND HEAD START PROGRAMS PER STATE EPSDT SCHEDULE\*\***

**\*\* Height @ Exam \_\_\_\_\_ \*\* B/P \_\_\_\_\_ \*\*Head Circumference (up to 12 months) \_\_\_\_\_ \*\***

**\*\* HCT/HGB \_\_\_\_\_ \*\* Lead Level  Not at risk or Level \_\_\_\_\_**

**\*\*TB  Not at risk or Test Results  Normal  Abnormal**

**\*\*Screenings Performed:  Vision:  Normal  Abnormal  Hearing:  Normal  Abnormal  Dental:  Normal  Abnormal-**

**Recommended Follow-up \_\_\_\_\_**

**Provider Signature**

Next Well Visit:  Per AAP guidelines\* or  Age \_\_\_\_\_

This child is healthy and may participate in all routine activities in school sports, child care or camp program. 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, #

The Colorado Chapter of the American Academy of Pediatrics (AAP) and Healthy Child Care Colorado have approved this form. 04/07

\*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.

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# COLORADO CERTIFICATE OF IMMUNIZATION

cdphe.colorado.gov/immunization



**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 Advisory Committee on Immunization Practices (ACIP) schedule. If the student provides an immunization record in any other format apart from this Certificate or an Approved Alternate Certificate (details found at [cdphe.colorado.gov/immunization/forms](http://cdphe.colorado.gov/immunization/forms)), the school health authority must transcribe the record onto this form. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at sixth grade entry.

Student Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Parent/guardian:(if student is under 18 years of age and not emancipated) \_\_\_\_\_

Required Vaccines	Immunization date(s) MM/DD/YY	Titer Date* MM/DD/YY
HepB Hepatitis B		
DTaP Diphtheria, Tetanus, Pertussis (pediatric)†		
Tdap Tetanus, Diphtheria, Pertussis†		
Td Tetanus, Diphtheria		
Hib <i>Haemophilus influenzae</i> type b		
IPV/OPV Polio		
PCV Pneumococcal Conjugate		
MMR Measles, Mumps, Rubella ‡		
Measles		
Mumps		
Rubella		
Varicella Chickenpox		

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

Varicella - date of disease		Varicella - positive screen date	
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In several instances, laboratory confirmation of positive titers are an acceptable alternative to written documentation of vaccination. A positive laboratory titer report must be provided to the school to document immunity. More information on titers can be found within the Colorado Board of Health rule 6 CCR 1009-2.

† For DTaP and Tdap, both the diphtheria and tetanus titers must be positive. A titer is never acceptable to demonstrate immunity to pertussis.

‡ Laboratory confirmation of positive titers are an acceptable alternative to the MMR vaccine only when titers for all three components (measles, mumps, and rubella) are positive.

Recommended Vaccines	Immunization date(s) MM/DD/YY
HPV Human Papillomavirus	
RV Rotavirus	
MCV4 Meningococcal	
MenB Meningococcal	
HepA Hepatitis A	
Flu Influenza	
COVID-19	
Other	

Health care provider printed name/signature: \_\_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_

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

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: \_\_\_\_\_

ATTENTION PARENTS/GUARDIANS

This letter is to ensure that your child has his/her proper medical forms which will support our program in providing a healthy and safe environment for your child.

- Children needing any medication during program hours require **medication authorization(s)** that are signed by your health care provider.
  - Children with **severe allergies** requiring medication are required to have a completed health care plan that is signed by your health care provider.
  - Children with **asthma** that regularly require asthma medication during program hours are required to have a completed asthma health care plan that is signed by your health care provider.
  - Children with **special health conditions** are required to have a completed health care plan signed by your health care provider. This plan will be individually designed for your child; as delegated by the program's nurse consultant, the program staff and the child's guardian(s).
- 

**To Be Completed and Returned By Parent/Guardian**

- Does your child have any food exclusions due to an allergic reaction to the food?                      YES                      NO  
if yes, please list food and your child's reaction to exposure:  
Food    Reaction    Medication  
  
\_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_  
\_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_
- Does your child have any other allergies requiring medications or special attention?    YES    NO
- Does your child have a special health condition (such as seizures, diabetes, feeding tube, oxygen, etc.) that requires special attention by center staff?

If yes to any of the above, please circle the appropriate response below:

- I will provide a Health Care Plan signed by my child's health care provider.
- I understand that the nurse consultant will review the health care plan and is available to assist in this process.
- I do not want a HCP for my child at this time.
- Please do not serve these foods to my child at this time.

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

# RRCC Children's Center Door Access Badge Parent Contact Information

Child's Name 1: \_\_\_\_\_

Child's Name 2: \_\_\_\_\_

Parent 1 Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Work Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Parent 2 Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Work Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Other Authorized Adult: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Parents/Other Adults are responsible for keeping track of their access badges. If you lose your badge, please contact Campus Police immediately at 303-914-6394 so that we can deactivate your badge and schedule a time to get you a new one. The initial cost for your first badge is \$10/badge. The cost to replace a lost badge is \$10.00. The fees can be paid at the cashier's

## RRCC Emergency Alert Messaging

In the event of a campus closure due to weather or an emergency due to an imminent threat, you will be notified immediately. In order to OPT IN to RRCC Emergency Alert text message notifications please check the box below and provide the mobile number(s) that you would like the text messages to be sent to. If you need to update your phone number or OPT OUT please contact the Police Services Manager via email at [loretta.talfoya@rrcc.edu](mailto:loretta.talfoya@rrcc.edu)

OPT IN to Text Messaging Emergency Alert Notifications

Mobile Number(s): \_\_\_\_\_

You will automatically be subscribed to email and voice call alerts with the email address and phone number(s) that we have on file.

Parent 1 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent 2 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Other Adult Signature: \_\_\_\_\_ Date: \_\_\_\_\_

CC Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

VP Signature Approval: \_\_\_\_\_ Date: \_\_\_\_\_

### Internal Use Only

Initials of Person Processing Badge: \_\_\_\_\_ Time: \_\_\_\_\_ Date Processed: \_\_\_\_\_

Signature of PSM: \_\_\_\_\_ Date Received by PSM: \_\_\_\_\_