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

Form (signed by both parents if applicable)

___Family Handbook Agreement

___Signed Permission Forms

___General Health Appraisal Form signed by physician

___Current records of immunization

___Allergy, Asthma, and Special Health Conditions

___Health Care Plan, if required

___USDA Income Eligibility Form

___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.

Children's Center @ Red Rocks Community College 303-914-6328

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 <u>emergency</u> and who are <u>authorized</u> 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 10th 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/rrcccdcpay. 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 1week 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_________________

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

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.

Student Name: ______________________ **Date of birth:** ____________

Parent/guardian: ______________________

Required Vaccines

Vaccine	**Immunization date(s)** MM/DD/YY						**Titer Date*** MM/DD/YY
Hep B Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)							
Tdap Tetanus, Diphtheria, Pertussis							(shaded)
Td Tetanus, Diphtheria							
Hib *Haemophilus influenzae* type b							(shaded)
IPV/OPV Polio							(shaded)
PCV Pneumococcal Conjugate							(shaded)
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

Vaccine	**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: ____________

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 CONTROL BADGE REQUEST APPLICATION

College procedure requires parents/other approved adults, requiring access to the RRCC Children's Center secured area, to submit an access control badge request application. By signing and submitting an application, you confirm you have read and understand the below information.

- You are fully responsible for the safekeeping and proper use of your access control badge.
- You are required to immediately report a lost or stolen badge to the RRCC Police Department so the missing access control badge can be deactivated.
- The access control software records each time a security access badge is used for access.
- You are prohibited from loaning or borrowing badges, admitting unauthorized personnel or gaining unauthorized access to campus facilities.
- You are required to protect your access control badge from damage caused by bending, cracking, breaking or hole-punching, or by exposure to heat, pets, washing machines, etc.
- You are required to inform the RRCC Police Department of any changes to your association with the College.
- Your access control badge is college property and must be returned to the RRCC Police Department when you are no longer associated with the College.
- The initial cost for each badge is $10.00. The replacement fee for a lost, or damaged (due to negligence) access control badge is $10.00. Payments must be submitted through the RRCC Cashier's Office and receipts are required prior to the issuance of an access control badge.
- RRCC Emergency Alert Messaging: In the event of an unforeseen campus closure or an emergency, you will be notified immediately via the College's emergency alert system. In order to "OPT IN" to RRCC Emergency Alerts, please type/write "OPT IN" on the emergency notification line and include the cellphone number(s) you would like to receive emergency alert text messages to. You will automatically be subscribed to receive email and voice alerts with the email and phone number(s) you provide.
- Completed applications should be submitted to the College Police Department for processing. You will be notified once processed and asked to setup an appointment to take a photo and pick up your access control badge.

GENERAL INFORMATION:

Child's Name (1)	
Child's Name (2)	

PARENT INFORMATION (1):

Last Name, First Name	
Phone Number	
Email Address	
Emergency Alert Notifications	
Signature	

RRCC CHILDREN'S CENTER DOOR
ACCESS CONTROL BADGE REQUEST APPLICATION

PARENT INFORMATION (2):

Last Name, First Name	
Phone Number	
Email Address	
Emergency Alert Notifications	
Signature	

OTHER AUTHORIZED ADULT:

Last Name, First Name	
Phone Number	
Email Address	
Emergency Alert Notifications	
Signature	

RRCC CHILDREN'S CENTER DIRECTOR APPROVAL:

Director Printed Name	
Director Signature	
Date Signed	

DIVISION VICE PRESIDENT | PRESIDENT APPROVAL:

VP | President Printed Name	
VP | President Signature	
Date Signed	

PD USE ONLY:

Date Request Received:	
PD Leadership Approval:	
Date IT Ticket Created:	
Date of Badge Completion:	