

## GENERAL HEALTH APPRAISAL FORM

### PARENT please complete AND SIGN

|  |                  |
|--|------------------|
| Child's Name: _____  | Birthdate: _____ |
| Allergies: <input type="checkbox"/> None or Describe _____<br>Type of Reaction _____   |                  |
| Diet: <input type="checkbox"/> Breast Fed <input type="checkbox"/> Formula _____ <input type="checkbox"/> Age Appropriate  |                  |
| <input type="checkbox"/> Special Diet _____  |                  |
| Sleep: Your health care provider recommends that all infants less than 1 year of age be placed on their back for sleep.  |                  |
| <input type="checkbox"/> 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: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (Specify any physical abnormalities) _____  |                      |
| Allergies: <input type="checkbox"/> None or Describe _____ Type of Reaction _____  |                      |
| Significant Health Concerns: <input type="checkbox"/> Severe Allergies <input type="checkbox"/> Reactive Airway Disease <input type="checkbox"/> Asthma <input type="checkbox"/> Seizures <input type="checkbox"/> Diabetes <input type="checkbox"/> Hospitalizations<br><input type="checkbox"/> Developmental Delays <input type="checkbox"/> Behavior Concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Dental <input type="checkbox"/> Nutrition <input type="checkbox"/> Other _____ |                      |
| Explain above concern (if necessary, include instructions to care providers): _____  |                      |
| Current Medications/Special Diet: <input type="checkbox"/> None or Describe _____  |                      |
| Separate medication authorization form is required for medications given in school, child care or camp   |                      |
| <b>For Fever Reducer or Pain Reliever (for 3 consecutive days without additional medical authorization) PLEASE CHOOSE ONE PRODUCT</b>  |                      |
| <input type="checkbox"/> Acetaminophen (Tylenol) may be given for pain or fever over 102 degrees every 4 hours as needed<br>Dose _____ or see the attached age-appropriate dosage schedule from our office   |                      |
| OR <input type="checkbox"/> Ibuprofen (Motrin, Advil) may be given for pain or for fever over 102 degrees every 6 hours as needed<br>Dose _____ or see the attached age-appropriate dosage schedule from our office  |                      |
| Immunizations: <input type="checkbox"/> Up-to-Date <input type="checkbox"/> See attached immunization record <input type="checkbox"/> Administered today: _____  |                      |

### Health Care Provider: Complete if Appropriate

|  |
|--|
| <b>**ONLY REQUIRED BY EARLY HEAD START AND HEAD START PROGRAMS PER STATE EPSDT SCHEDULE**</b>  |
| ** Height @ Exam _____ ** B/P _____ **Head Circumference (up to 12 months) _____ **  |
| ** HCT/HGB _____ ** Lead Level <input type="checkbox"/> Not at risk or Level _____   |
| **TB <input type="checkbox"/> Not at risk or Test Results <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal  |
| **Screenings Performed: <input type="checkbox"/> Vision: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Hearing: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Dental: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal- |
| Recommended Follow-up _____  |

### Provider Signature

|   |
|---|
| Next Well Visit: <input type="checkbox"/> Per AAP guidelines* or <input type="checkbox"/> 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: _____  |

|                                  |
|----------------------------------|
| <b>Office Stamp</b>              |
| Or write Name, Address, Phone, # |
|                                  |

Registration Form for St. Michael's Preschool

Name of Child \_\_\_\_\_

Date of Birth \_\_\_\_\_ Male or Female \_\_\_\_\_

Address \_\_\_\_\_

City, Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

NAMES OF PARENTS OR GUARDIANS

**Mother**

**Father**

**Employer**

**Employer**

**Work Phone**

**Work Phone**

**Cell Phone**

**Cell Phone**

Please read the following questions and check all that apply.

Are you Catholic? \_\_\_\_\_ Non-Catholic? \_\_\_\_\_

Are you a registered St. Michael's Parish Member? YES \_\_\_\_\_ NO \_\_\_\_\_

What parish are you registered in (if not St. Michael's)? \_\_\_\_\_

For the following question please check only one. What is your child's ethnic background?

American Indian/Native Alaskan \_\_\_\_\_

Black \_\_\_\_\_

Asian \_\_\_\_\_

Hispanic \_\_\_\_\_

Native Hawaiian/Pacific Islander \_\_\_\_\_

Caucasian \_\_\_\_\_

Middle Eastern \_\_\_\_\_

Multi Racial \_\_\_\_\_

\*\*A registration fee of \$75.00 must accompany this application. This fee is non-refundable.\*\*

PLEASE CHECK THE CLASS YOU ARE INTERESTED IN

Child's Age \_\_\_\_\_

*Morning Class (8:45 to 11:15)*

*Afternoon Class (12:30 to 3:00)*

MWF \_\_\_\_\_

MWF \_\_\_\_\_

TTH \_\_\_\_\_

TTH \_\_\_\_\_

MTWRF \_\_\_\_\_

MTWRF \_\_\_\_\_

\*\*Please Note: Teachers are not assigned classrooms until summer.\*\* DO NOT WRITE BELOW THIS LINE\*\*

FOR SCHOOL USE ONLY

YOUR CHILD IS ENROLLED FOR THE FOLLOWING CLASS SCHEDULE

MWF Morning

MWF Afternoon

Waitlisted in another class time:

TTH Morning

TTH Afternoon

MTWRF Morning

MTWRF Afternoon

Paid Check # \_\_\_\_\_ / Cash \_\_\_\_\_ / Credit Card Number \_\_\_\_\_

Approved \_\_\_\_\_ Date \_\_\_\_\_

**ST. MICHAEL'S PRESCHOOL**  
HEALTH STATUS FOR ENROLLMENT FORM

Children who enroll in child care programs must submit a signed and dated statement of the child's current health status which indicates the child's abilities and/or limitations to participate in a regularly scheduled program of play in a group of young children. This report is to be filled out by a licensed physician of a licensed nurse practitioner who has seen the child in the last twelve months.

Health Record For: St. Michael's Preschool Program

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_

**Past Illnesses** \*Indicate those that the child has had by giving the approximate date

|                       |               |                 |
|-----------------------|---------------|-----------------|
| Chicken Pox _____     | Rubeola _____ | Rubella _____   |
| Rheumatic Fever _____ | Asthma _____  | Hay Fever _____ |
| Diabetes _____        | Mumps _____   | Epilepsy _____  |
| Whooping Cough _____  | Polio _____   | Other _____     |

This child is \_\_\_\_\_ is not \_\_\_\_\_ physically or emotionally able to participate in the day care program named above.

Comments: \_\_\_\_\_

**Surgery/Accidents/Illnesses/Chronic or Handicapping Problems** \_\_\_\_\_

Describe any physical condition(s) requiring special attention by the preschool staff \_\_\_\_\_

Medications prescribed \_\_\_\_\_

Any known allergies (drug or otherwise) \_\_\_\_\_

Prescribed routine for treatment of allergies \_\_\_\_\_

Vision \_\_\_\_\_ Hearing \_\_\_\_\_

Please provide a record of the immunizations and the date they were administered on the Colorado Department of Health Certificate of Immunization and attach to this form.

Date of the most recent examination of this child \_\_\_\_\_

Signature of the physician or nurse practitioner \_\_\_\_\_

Please print the name and address of the physician or nurse practitioner \_\_\_\_\_

SECTION I: GENERAL INFORMATION

Teacher \_\_\_\_\_

Room Number \_\_\_\_\_

Student Name Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Student Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Student Lives With \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Student Address (include city and zip) \_\_\_\_\_

If Catholic, Parish Affiliation \_\_\_\_\_

In case of illness or emergency, who should be contacted first \_\_\_\_\_

Mother/Guardian Information

Last Name \_\_\_\_\_ First \_\_\_\_\_

Home Address (include city and zip) \_\_\_\_\_

Place of Employment (include address) \_\_\_\_\_

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

E-mail address \_\_\_\_\_

Father/Guardian Information

Last Name \_\_\_\_\_ First \_\_\_\_\_

Home Address (include city and zip) \_\_\_\_\_

Place of Employment (include address) \_\_\_\_\_

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

E-mail address \_\_\_\_\_

Student lives with

(If your child is picked up after school by a day care center or a permanent babysitter, please indicate this information below)

Name of child care person/center \_\_\_\_\_

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

SECTION II: PERSONS AUTHORIZED TO PICK UP CHILD (INCLUDING PARENTS/GUARDIAN)

(Under no circumstances will the child be released to anyone not known to the school without written authorization from the parents/legal guardian)

Name Last \_\_\_\_\_ First \_\_\_\_\_ Relationship \_\_\_\_\_

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

Address (include city and zip) \_\_\_\_\_

Name Last \_\_\_\_\_ First \_\_\_\_\_ Relationship \_\_\_\_\_

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

Address (include city and zip) \_\_\_\_\_

Name Last \_\_\_\_\_ First \_\_\_\_\_ Relationship \_\_\_\_\_

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

Address (include city and zip) \_\_\_\_\_

SECTION III: SPECIFIC PERSONS NOT AUTHORIZED TO PICK UP CHILD

(Please include a copy of appropriate court order or legal documentation)

Name Last First Relationship
Name Last First Relationship
Name Last First Relationship

SECTION IV: EMERGENCY CONTACT PERSONS

Other than parents/guardians)

Name Last First Relationship
Phone Home Work Cell
Address (include city and zip)

Name Last First Relationship
Phone Home Work Cell
Address (include city and zip)

SECTION V: MEDICAL INFORMATION

Doctor's Name Phone

Doctor's Address (include city and zip)

Allergies

Chronic Medical Conditions(s) (e.g. diabetes, heart disease, contacts, hearing aids, asthma, epilepsy etc)

Medication(s) Student is Currently Taking

Is medication needed at school? Yes No Name of Medication
(If yes, complete the medication form located in the school handbook)

Hospital Preference Name City

Medical Insurance Company Policy Number

Dentist's Name Phone

Dentist's Address (include city and zip)

SECTION VI: MEDICAL AUTHORIZATION

I give the school my permission to take my child to a hospital to receive emergency treatment. I hereby consent to any x-ray examination, medical or surgical diagnosis or treatment, and hospital care to be rendered to my child under the general or direct supervision and upon the advice of a physician and surgeon licensed under the provisions of the Medical Practice Act. I also consent to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered to my child by a dentist under the provisions of the Dental Practice Act. I authorize the medical facility to release my child into the custody of a school representative should hospital care no longer be needed. I understand that this is only in an extreme emergency and when the parent or legal guardian cannot be reached. I understand that I am responsible for any expenses incurred by the medical and/or dental diagnosis or treatment. I agree to pick up my child if he/she is sick or injured. If I cannot be reached the above emergency contacts can be called to pick up my child.

Signature Date

SECTION VII: STUDENT RECORDS UPDATE

(I understand that I must keep my child's records up to date with current information)

Parent or Legal Guardian's Signature Date

## St. Michael the Archangel Preschool

### PERMISSION FORM

I hereby grant permission for my child to use all of the play equipment and participate in all of the activities of the school. YES \_\_\_\_\_ NO \_\_\_\_\_

I hereby grant permission for my child's name, parent's name, address and phone number to be included in the school directory. YES \_\_\_\_\_ NO \_\_\_\_\_

I hereby grant permission for my child to leave the school premises under the supervision of a staff member for neighborhood walks. YES \_\_\_\_\_ NO \_\_\_\_\_

I hereby grant permission for my child to be included in evaluations and pictures connected with the school program. YES \_\_\_\_\_ NO \_\_\_\_\_

I hereby grant permission for the Director or Acting Director to take whatever steps may be necessary to obtain emergency medical care if warranted. These steps may include but are not limited to the following:

1. Attempt to contact parent or guardian
2. Attempt to contact child's physician
3. Attempt to contact you through any of the person(s) listed on the emergency information form you completed for us.

If we cannot contact you or your child's physician we will do any or all of the following:

- Call another physician or paramedics
- Call an ambulance (will be accompanied by a staff member)

Any expenses incurred from the above actions will be borne by the child's family.

YES \_\_\_\_\_ NO \_\_\_\_\_

*\*The school will not be responsible for anything that may happen as a result of false information given at the time of enrollment. Please see the Director to update the various forms if changes occur during the school year (ie new phone number or new address).*

*\*The school will not assume responsibility for a child who has not been signed in when he/she arrives for the day.*

I have read and understood all of the information included on this form.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Mother or Legal Guardian

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Father or Legal Guardian

Child's Name \_\_\_\_\_  
(Please print neatly)

## Developmental Information

### Family History

Child's Sibling(s)

|            |                     |                       |
|------------|---------------------|-----------------------|
| Name _____ | Date of Birth _____ | Grade In School _____ |
| Name _____ | Date of Birth _____ | Grade In School _____ |
| Name _____ | Date of Birth _____ | Grade In School _____ |
| Name _____ | Date of Birth _____ | Grade In School _____ |
| Name _____ | Date of Birth _____ | Grade In School _____ |

Other Members of the Household (include relationship and age)

Pertinent Information You Would Like Your Child's Teacher To Know:

Who has cared for the child other than parents (state whether adults or teenagers)?

Has your child had any group play experiences? \_\_\_\_\_  
Where? \_\_\_\_\_

Do you or your spouse have any special talents that you can share in the classroom, or with the teachers if needed? (i.e. occupations that might interest a child, playing a musical instrument, sewing, etc...)

### Developmental History

Word child uses for urination? \_\_\_\_\_ Bowel Movements? \_\_\_\_\_

Dietary restrictions? \_\_\_\_\_

Favorite Indoor Activity? \_\_\_\_\_

Favorite Outdoor Activity? \_\_\_\_\_

Any special fears that you are aware of? \_\_\_\_\_

Any speech concerns? \_\_\_\_\_

Any other concerns? \_\_\_\_\_

Any surgeries (in or outpatient)? \_\_\_\_\_

What method of behavior control is used at home? \_\_\_\_\_

How would you describe your child's personality? \_\_\_\_\_