



Emergency Contact Form

Child's Name _____ Nick Name _____

D.O.B _____ Date of Enrollment _____ Jeffco ID # _____

Home Address _____ Phone _____

Parent/Guardian Name _____ Cell Phone _____

Home Address (if different) _____ Email _____

Employer _____ Address _____ Phone _____

Parent/Guardian Name _____ Cell Phone _____

Home Address (if different) _____ Email _____

Employer _____ Address _____ Phone _____

Emergency Contact Person (Persons to be contacted if parents/guardians cannot be reached)

1) Name _____ Cell _____ Alt Phone _____

Address _____ Relationship _____

2) Name _____ Cell _____ Alt Phone _____

Address _____ Relationship _____

Additional Persons Authorized to Pick up Child

1) Name _____ Cell _____ Alt Phone _____

Address _____ Relationship _____

2) Name _____ Cell _____ Alt Phone _____

Address _____ Relationship _____

Medical Information

Hospital _____ Phone _____ Address _____

Doctor _____ Phone _____ Address _____

Dentist _____ Phone _____ Address _____

AUTHORIZATION FOR EMERGENCY MEDICAL CARE AND TRANSPORTATION

In the event of an emergency I hereby give my permission for Great Work Montessori School staff to access emergency medical services for my child, including transport to the nearest healthcare facility, to receive emergency medical or surgical care and treatment. It is understood that a conscientious effort will be made to locate me, and I accept the expense of care and transport. I certify that the information I have provided is true to the best of my knowledge. If any of the information changes I will notify Great Work Montessori School immediately.

Parent/Guardian 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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