Emergency Contact Information

Child's Name:________________________________ DOB:__________________ Child+#:_______________

Emergency Contact Name:		**Relationship to child:**	
Street Address: City, State, Zip:			
Phone #'s:	☐ Home ☐ Cell ☐ Home ☐ Cell	**Check all that apply** ☐ **Emergency contact** ☐ **Release child To** **Is this person at least 16 years old with a valid government ID?** ☐ **Yes** ☐ **NO**	

Emergency Contact Name:		**Relationship to child:**	
Street Address: City, State, Zip:			
Phone #'s:	☐ Home ☐ Cell ☐ Home ☐ Cell	**Check all that apply** ☐ **Emergency contact** ☐ **Release child To** **Is this person at least 16 years old with a valid government ID?** ☐ **Yes** ☐ **NO**	

Emergency Contact Name:		**Relationship to child:**	
Street Address: City, State, Zip:			
Phone #'s:	☐ Home ☐ Cell ☐ Home ☐ Cell	**Check all that apply** ☐ **Emergency contact** ☐ **Release child To** **Is this person at least 16 years old with a valid government ID?** ☐ **Yes** ☐ **NO**	

Child's Name:_____ **DOB:**_____ **Child+#:**_____

	Permission Contract	**Initial All**
Release of Information	I authorize the Poudre School District Early Childhood Education Program to release information to the health, medical, nutrition and dental community providers listed below as identified by the parent/guardian. **Heath Provider☐ WIC Program☐ Dentist☐ Other:☐**	
Data Collection	I understand that the Poudre School District Early Childhood Education Program collects non-identifiable statistical information to be used for documentation, Program Information Report and funding purposes.	
Data Collection	I understand that the Poudre School District Early Childhood Education Program collects non-identifiable statistical information to be used for documentation, Program Information Report and funding purposes.	
Permission for Including Children in Media	I give permission to Poudre School District Early Childhood Education Program to include my child in a school district video, article, or news release or social media posting (Facebook, Instagram, twitter). These may be used for training purposes for teachers and/or promotional purposes for the Poudre School District Early Childhood Education Program. **☐ Agree ☐ Disagree**	
Telephone Contact	I give my permission for the program staff to give my telephone number to another parent for the purpose of program/classroom events and parent involvement only. **☐ Agree ☐ Disagree**	
Home Visits and Conferences	I understand that there will be home visits and Parent/Teacher Conferences required for 90 minutes per month during the school year provided by the Education, Health and Family Mentor staff. If I am unable to make a scheduled visit, I must reschedule within the same month. I understand that lack of attendance at home visits will lead to a review of my child's enrollment and may lead to disenrollment	
Quality Assurance	I understand that there may be a supervisor who comes into my home during a scheduled home visit with one of the staff members mentioned above for the purpose of quality assurance.	
Parent Involvement	I understand that the Early Childhood Education Program highly encourages Parent Involvement and I am expected to participate in the program.	
Screenings	I understand that my child will be screened at intake and, if enrolled, throughout the school year for the purpose of assessment in vision, hearing, dental, speech and growth developmental needs. I give my permission for the PSD Early Childhood Education Program to conduct these screenings.	
Poudre School District Cumulative File	I understand that if my child is enrolled in a Poudre School District Early Childhood Education Program, my child's records will be transferred to his/her Poudre School District cumulative file.	
Custody and Court Order	I understand that I must provide Custody and Court Orders that pertain to my child to the Early Childhood Education Program in order for the school to be aware of and follow special instructions.	
Center-based Agreement	I understand that I am receiving child care at no cost during the following days and times: _____ I commit to attending these times and calling the center when my child will not attend. I understand that attendance issues will lead to a review of my child's enrollment and possible disenrollment. I understand that this is not a drop-in care situation.	
Center-based Enrollment	I understand that once my child turns three, they no longer qualify for center-based care through EHS and that I will need to switch to the home-based EHS program or obtain care from the center on my own.	

This form is valid for the 2020-2021 school year

X_____

Parent/Guardian Signature **Print Name** **Date**

Family Changes

Have there been any big changes in your family's life in the last 12 months (check all that apply):

Marriage ☐yes ☐no
Divorce ☐yes ☐no
Domestic Violence ☐yes ☐no
Moved: ☐yes ☐no
Abuse (sexual, physical, emotion) ☐yes☐no
Other (please describe:

Death ☐yes ☐no
Loss of job ☐yes ☐no
Incarceration ☐yes ☐no
Parent Deployment ☐yes ☐no
Foster placement ☐yes ☐no

Please describe when the changes occurred and your child's reaction:

Household Health Inventory

Do members of this child's family have any of the following:

Name & Relation to child	
	Emotional difficulties
	Depression
	Psychiatric Diagnosis
	Mental Health
	Drug use
	Smoking
	Alcoholism

INFORMATION VERIFICATION

By my signature below, I am verifying that the information provided to the Poudre School District Early Childhood Education Program on this health extension packet is, to the best of my knowledge, complete and truthful.

Parent/Guardian Signature **Print Name** **Date**

Who completed this application: ☐Mother ☐ Father ☐ Guardian

ERSEA Staff Signature **Print Name** **Date**

2020-2021 Health Conditions

Student Name: _____ Date of Birth: _____

Health Care Provider/ Medical Clinic: _____ Last exam date: _____

Dentist/ Dental Clinic: _____ Last exam date: _____

Are you enrolled in Supplemental Nutrition Assistance Program (SNAP) ☐ Yes ☐ No

Is your family currently on WIC ☐ Yes ☐ No

Medical Insurance:

☐ Medicaid/Health First ☐ Colorado Health Plan Plus (CHP+) ☐ None/Uninsured ☐ Other_____

Hospital Preference:

☐ Poudre Valley Hospital ☐ McKee Medical Center ☐ Medical Center of the Rockies ☐ Banner Health

Health Conditions:

Response		Health Condition	Response		Health Condition
YES	NO	Allergy- Environmental / Animal	YES	NO	Hearing Impairment- Devices worn? YES NO
YES	NO	Allergy – Food	YES	NO	Heart Condition
YES	NO	Allergy – Insect	YES	NO	Kidney /Urinary
YES	NO	Allergy - Medication	YES	NO	Mental Health
YES	NO	Asthma	YES	NO	Neurological
YES	NO	Autism Spectrum Disorder	YES	NO	Orthopedic
YES	NO	Brain / Head Injury	YES	NO	Physical limitation/restrictions
YES	NO	Cancer	YES	NO	Premature or significant birth history
YES	NO	Chewing or swallowing troubles	YES	NO	Seizures/ Epilepsy
YES	NO	Diabetes	YES	NO	Special Diet
YES	NO	G-Tube	Yes	NO	Vision Problem – Glasses worn? YES NO
YES	NO	Genetic Disorder	OTHER:		

Explain any health condition(s) above:_____

_____

_____

Does your child need medication at school? YES ☐ NO ☐

Name of Medication(s):_____

**Print or request an *Authorization to Administer Medication* form from your school or from the PSD health services website:

Please list any other daily medication(s) that your child is taking at home: _____

I voluntarily provide this information and understand I must provide the following health documents for my child's health file: Complete immunizations, current physical exam, dental exam and lead blood test results

_____

Parent/Guardian Signature **Date**

11/19/19

Early Childhood
HOME LANGUAGE AND STUDENT RESIDENCY FORM

State and federal regulations **require** that schools identify and report the language(s) spoken and heard by each child in the home, and determine eligibility for immigrant, migrant, refugee or McKinney education services. This information is used to ensure that the educational rights of each child are met. Please take a few minutes to complete this questionnaire. **This confidential information is for school use only.**

Student's Last Name _____ Student's First Name _____ Student's Middle Name _____

Student's Date of Birth _____ Country of Birth _____

Address: _____

Date Student Entered Colorado _____ Date Student Entered USA _____

Parent or Guardian Name(s) _____

Home Phone #: _____

Work Phone #: _____

Home Language Information:

Was the language first spoken by the student a language other than English?	☐ No	☐ Yes	Language:
Does the student speak a language other than English?	☐ No	☐ Yes	Language:
Is a language other than English used in the home?	☐ No	☐ Yes	Language:
Will you need an interpreter for conferences, phone calls and other verbal communication?	☐ No	☐ Yes	Language:

Residency Information:

Have you been given "Refugee Status" paperwork? ☐ No ☐ Yes

Did you move to Colorado with the intent of working in agriculture, farming or fishing? ☐ No ☐ Yes

Do you work in agriculture, farming or fishing? ☐ No ☐ Yes

Housing Information

The McKinney-Vento Assistance Act protects and supports the educational rights of students who do not have permanent housing. Your answers help to determine the support the student may be eligible for.

*This **confidential information** is for school use only*

A. Please check which of the following situations the student resides in (you can choose more than one):

___ Living with extended family members, non-family members, or friends
___ Motel, car, campsite, or park
___ Shelter (emergency, safehouse) or transitional housing program
___ Inadequate housing (lacks proper kitchen, bathroom facilities, water or electricity, and/or infestations, mold, or other dangers)
___ None of the above
___ Other (Please Explain)

B. Please check all the following reasons that apply to the students living situation (you can choose more than one):

___ Loss of housing
___ Economic hardship
___ Temporarily waiting for house or apartment
___ Providing care for a family member
___ Living with boyfriend/girlfriend/significant other/friend
___ Loss of employment
___ Parent/Guardian deployed
___ None of the above
___ Other (Please explain)

C. My student is living apart from his/her parents or guardians. ☐ Yes ☐ No

Educational Rights

1. Go to school no matter where they live or how long they have lived there
2. Choose between the local school where they are living, the school they attended before they lost their housing, or the school where they were last enrolled
3. Enroll in school without proof of address, immunizations, school records, or other documents
4. Have access to extracurricular activities
5. Get transportation to their school of origin (if feasible and in their educational best interest)
6. Get all the school services they need (including free breakfast/lunch, fees waived)
7. Be free from harassment and isolation
8. Have disagreements with the schools settled quickly

Any questions about these rights can be directed to the local McKinney-Vento Program Specialist at

Signature of parent or guardian Date

Authorization for Disclosure of Protected Health Information

Doctor

PARENT TO COMPLETE

I authorize _____

(Provider/Clinic Name)

_____

(Provider/Clinic address and or Street)

to release the Health Information of the individual named below

Patient/Student Name _____ DOB _____

Address _____

Phone Number _____ Parent Name _____

PSD HEALTH STAFF TO COMPLETE

I authorize the information to be disclosed to and discussed with the following individual(s) or organization(s):

Poudre School District Early Childhood Health Staff
220 North Grant Fort Collins CO 80521 Fax 970-490-3134

For the purpose of: PSD Early Childhood Health Requirements

The type and amount of information to be disclosed is as follows: *(specify dates where appropriate):*

- Entire medical record, from date _____ to date _____.
- Summary statement of diagnostic testing and treatment plan, from date _____ to date _____.
- Laboratory Result, from date _____ to date _____.
- Immunizations records, from date _____ to date _____.
- Well-child exam, from date _____ to date _____.
- Dental exam, from date _____ to date _____.
- Developmental reports and evaluations, from date _____ to date _____.
- Other: _____
- (You must specifically indicate the release of records relating to drug or alcohol abuse, child abuse, HIV status, genetic testing, or mental health records. A separate authorization form is required for release of psychotherapy notes.)
- Verbal consultation as needed with _____

PARENT TO READ AND SIGN

I understand this authorization will expire, without my express revocation one year from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that I have a right to a copy of this authorization. I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. Treatment, payment, enrollment in the health plan or eligibility for benefits may not be conditioned on obtaining the individual's authorization. I understand that any disclosure of information carries with it the potential for re-disclosure and once the information is disclosed, it may no longer be protected by federal HIPAA confidentiality rules.

_____ _____

Signature of Patient, Parent or Authorized Personal Representative **Date**

_____ _____

Printed Name of Patient, Parent or Authorized Personal Representative **Relationship** to Patient

This authorization reflects the requirements of HIPAA, 45 C.F.R.J 164.508.

Authorization for Disclosure of Protected Health Information

Dentist

PARENT TO COMPLETE

I authorize _____

(Provider/Clinic Name)

_____

(Provider/Clinic address and or Street)

to release the Health Information of the individual named below

Patient/Student Name _____ DOB _____

Address _____

Phone Number _____ Parent Name _____

PSD HEALTH STAFF TO COMPLETE

I authorize the information to be disclosed to and discussed with the following individual(s) or organization(s):

Poudre School District Early Childhood Health Staff
220 North Grant Fort Collins CO 80521 Fax 970-490-3134

For the purpose of: Early Childhood Health Requirements:

The type and amount of information to be disclosed is as follows: *(specify dates where appropriate):*

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- Other: _____
- (You must specifically indicate the release of records relating to drug or alcohol abuse, child abuse, HIV status, genetic testing, or mental health records. A separate authorization form is required for release of psychotherapy notes.)
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PARENT TO READ AND SIGN

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_____ _____

Signature of Patient, Parent or Authorized Personal Representative **Date**

_____ _____

Printed Name of Patient, Parent or Authorized Personal Representative **Relationship** to Patient

This authorization reflects the requirements of HIPAA, 45 C.F.R.J 164.508.