



Student Emergency Information

Note: Please complete all spaces on this form with the names, addresses, phone, and other information, as it would be indicated on any legal form. List Legal Guardian information where applicable. If last names or addresses differ, please indicate so.

Student's Name: _____ Date of Birth: _____

Student's Primary Address: _____

Student's Primary Home Phone: _____

Student's Physician: _____ Physician Phone: _____

Physician Address: _____

Student's Dentist: _____ Dentist Phone: _____

Dentist Address: _____

Mother's Name: _____ Emergency Phone Number: _____

Address if different form Student: _____

Father's Name: _____ Emergency Phone Number: _____

Address if different form Student: _____

ALLERGIES

Does your child have any allergies to medications or anything else? Please list clearly:

To properly serve your child in case of ACCIDENT or SUDDEN ILLNESS, please indicate in the spaces below, the individual(s) we should contact and the order in which we should call them. Any changes to the information on this form must be brought to our attention immediately. Please remember that your child is under our care during the school day, and that we wish to be able to assist him/her in the manner that you yourself would consider most appropriate.

1st Contact Name: _____ Phone Number 1: _____

Address: _____ Phone Number 2: _____

2nd Contact Name: _____ Phone Number 1: _____

Address: _____ Phone Number 2: _____

3rd Contact Name: _____ Phone Number 1: _____

Address: _____ Phone Number 2: _____



Permission for Transportation to a Hospital

If my child falls ill or has an injury severe enough that may require emergency services, I give my permission to Discovery Trails Early Learning Academy, Inc. (Discovery Trails) to use the most appropriate means available to transport my child to the nearest hospital. I understand Discovery Trails is not responsible for any costs incurred for such transportation or for any medical costs involved. In the event that, for any reason, my child requires hospitalization, I understand that Discovery Trails will attempt to contact me and continue to attempt to contact me until I have been reached. If I cannot be reached, and my child must go to the hospital while I am being located, I give Discovery Trails my permission to show this document to hospital personnel, and authorize Discovery Trails to act in my behalf to authorize hospital personnel to proceed with any required treatment.

Hospital Preference: Check all that apply

_____ Memorial Hospital
1400 E. Boulder St
Colorado Springs, CO 80909
(719)365-5000

_____ Memorial North Hospital
4050 Briargate Parkway
Colorado Springs, CO 80920
(719)364-5000

_____ Penrose Main Hospital
2222 N. Nevada Ave.
Colorado Springs, CO 80907
(719)203-2797

_____ St. Francis Medical Center
6001 E. Woodmen Rd
Colorado Springs, CO 80923
(719)776-5000

_____ Other: Name: _____ Phone Number: _____

Address: _____

Child's Name: _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____



Picture Release Form

_____ Yes, I give permission for Discovery Trails to use my child's image on the website, on promotional materials and in the classroom. I understand my child's name will never be published.

_____ No, I do not give permission for Discovery Trails to use my child's image on the website, on promotional materials or in the classroom.

_____ I give permission for Discovery Trails to use my child's image in the classroom only. I understand that pictures of my child may be viewed by anyone who enters the building.

Child's Name _____

Parent Signature _____

Date: _____



Discovery Trails General Health Appraisal for Enrollment in School

(to be completed by a Health Care Professional)

Child's Name: _____

Birth Date: _____

Health History & Medical Information pertinent to routine childcare & emergencies:

_____ None _____ Describe:

Special Diet: _____
Medical, Religious or Preference (circle one)

Allergies: _____ Type of Reaction: _____

Consistent Medications: _____

Dosage _____ Time _____ Diagnosis _____

Describe any recurrent health problems (such as asthma, seizures, ear infections, diabetes, etc.) illness, hospitalization or concerns with development? _____ None

Comments: (include instructions to the teacher(s))

Date of most recent examination: _____ within the last 12 months

Weight _____ Height _____

Vision _____ Hearing _____ Dental Screening _____

Immunizations given and attach immunization record: _____

Health Provider/Prescriptive Authority Name _____ Date _____

Health Provider/Prescriptive Authority Signature _____

Address _____ Phone _____

I, _____ give consent for my child's health care provider & childcare
(name of parent/legal guardian)
provider to discuss my child's health concerns.

Parent/Guardian Signature

Date



Authorization to Pick-up Student From School

Name of Student: _____

Discovery Trails Early Learning Academy, Inc. (Discovery Trails) will not release a student from the school to an individual other than a parent/legal guardian without prior written authorization. Please list those individuals who have your permission to pick up your child from Discovery Trails.

INDIVIDUALS AUTHORIZED TO PICK UP STUDENT:

1. Name: _____ Phone Number: _____
Address: _____
2. Name: _____ Phone Number: _____
Address: _____
3. Name: _____ Phone Number: _____
Address: _____

I GIVE MY PERMISSION TO THE ABOVE INDIVIDUAL(S) TO PICK UP MY CHILD FROM DISCOVERY TRAILS. In the event an authorized person needs to pick my child up from Discovery Trails, I understand that as a safety precaution, a PASSWORD system has been set in place. I understand it is my responsibility to inform my authorized pick-up person of my child's password to allow my child to leave Discovery Trails under the supervision of this person.

My child's password is: _____

Discovery Trails' staff will not release a student to any individuals other than their parent/guardian unless the individual is both listed above **and** knows the student's password. ***Knowing the student's password will not be sufficient for Discovery Trails staff to release a student to any individual not listed on this form.***

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date



Family Information

The information below will be kept on file only and is confidential. Please fill in information accurately and return to the office. Thank you.

Student's Name:

First: _____ Middle: _____ Last: _____

Birth Date: _____ Enrollment Date: _____

Mother's Name: _____

Mother's Address: _____

Mother's Employer Name and Address: _____

Mother's Home Phone: _____ Mother's Work Phone: _____

Mother's Cell Phone: _____ Mother's E-mail Address: _____

Father's Name: _____

Father's Address: _____

Father's Employer Name and Address: _____

Father's Home Phone: _____ Father's Work Phone: _____

Father's Cell Phone: _____ Father's E-mail Address: _____



Sunscreen Permission Form

Name of Child: _____

Name of Sunscreen and SPF Number: _____

Expiration Date: _____

It is the policy of Discovery Trails Early Learning Academy, Inc. (Discovery Trails) that parents and/or guardians apply sunscreen to their child(ren) before school starts in the morning. Sunscreen is left at school in those cases where the parent(s) legitimately forgot to apply the sunscreen or we spend extended time outside. Discovery Trails staff will assist your child with applying sunscreen to bare surfaces including the face, tops of ears, bare shoulders, arms, legs, and feet 15-30 minutes before enjoying outdoor activities. Sunscreen will not be applied to any broken skin or to any skin that has shown a reaction. Any skin reaction that has been observed will be immediately reported to the parents. It is the parents' responsibility to provide sunscreen with an SPF of 15 or higher.

_____ In the event my child's sunscreen is not readily available, I give Discovery Trails permission to apply sunscreen provided by the school. I understand the sunscreen provided is **Banana Boat-Tear Free Continuous Spray** with an SPF of **50**.

_____ I do not want my child to have any sunscreen other than the one I provide.

Parent/Guardian Signature

Date



Video Permission Form

I understand that frequent video watching is not part of the philosophy of Discovery Trails Early Learning Academy, Inc. However, occasionally the option will arise that curricular-based videos may be shown. I understand that the video shown will be G-Rated and I will be notified with enough time to watch the video in advance and choose for my child not to watch it. I also understand that my child is not forced to watch the video and an alternate activity will be available.

_____ **Yes, my child has permission to watch age-appropriate, curricular-based videos.**

_____ **No, my child does not have permission to view videos.**

Child's Name: _____

Parent's Name: _____

Parent Signature: _____