B.A.S.E After School Program
Emergency Information Forms

* All areas must be filled in, if not applicable write N/A.

STUDENT INFORMATION

Start Date: School of Attendance:

Child's Name: Date of Birth: (Circle) M / F

Address: City, Zip Code:

1. PARENT or LEGAL GUARDIAN The parent or guardian who registers this child for the BASE After School Program is responsible for the weekly payments. Please sign below that you understand you are responsible for payment on your child's account. Any unpaid BASE balances will be turned over to collections and your Recreation Center household account will be frozen until payment is received. Signature: _____	**2. PARENT or LEGAL GUARDIAN** The parent or guardian who registers this child for the BASE After School Program is responsible for the weekly payments. Please sign below that you understand you are responsible for payment on your child's account. Any unpaid BASE balances will be turned over to collections and your Recreation Center household account will be frozen until payment is received. Signature: _____
Name:	Name:
Relationship to Child:	Relationship to Child:
Address:	Address:
City, Zip Code:	City, Zip Code:
Home Phone:	Home Phone:
Employer:	Employer:
Address:	Address:
City, Zip Code:	City, Zip Code:
Work Phone:	Work Phone:
Alternative Phone:	Alternative Phone:
Email:	Email:

AUTHORIZED PICK UP AND EMERGENCY CONTACT INFORMATION (Persons other than parent, to be notified) :

1. Name:	2. Name:
Relationship to Child:	Relationship to Child:
Address:	Address:
City, Zip Code:	City, Zip Code:
Home Phone:	Home Phone:
Alternative Phone:	Alternative Phone:

PROHIBITED AUTHORIZATION* (Names of persons, NOT authorized to pick up the child):

Name:	Name:
Relationship to Child:	Relationship to Child:
Address & Phone:	Address & Phone:

***If there are any custodial restrictions regarding this child the registering parent must provide copies of judicial orders documenting such restrictions to the City of Lafayette BASE After School Program prior to the child's participation**.

B.A.S.E. After School Program
Emergency Information Forms

* All areas must be filled in, if not applicable write N/A.

STUDENT INFORMATION

Child's Name: Date of Birth: (Circle) M / F

Date of my child's most recent health examination: _____

A copy of my child's immunization records are attached and on an CDPHE approved form: _____ (initial)

PAST ILLNESSES—CHECK THOSE THAT APPLY AND GIVE APPROXIMATE DATES:

_____	Chicken Pox	_____	Rubella	_____	Rheumatic Fever
_____	Asthma	_____	Hay Fever	_____	Whooping Cough
_____	Mumps	_____	Epilepsy	_____	Other
_____	Poliomyelitis	_____	Diabetes		

Comments: _____

Surgery / Accidents / Illnesses / Chronic Health Problems: _____

_____

Please list any medication (s) prescribed: _____

_____

Allergies: _____

Restrictions: _____

Dietary Restrictions: _____

INFORMATION REQUIRED BY LAW

Physicians Name: _____ Phone : _____

Address: _____ City / Zip Code: _____

Hospital Preferred for Emergency Treatment: _____ Phone: _____

Address: _____ City / Zip Code: _____

Health Insurance Company: _____ Policy or ID#: _____

Dentist: _____ Phone: _____

Address: _____ City / Zip Code: _____

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I, the undersigned, a parent or guardian of the above named child herein authorizes all adult sponsors, or any responsible adult person bearing this written authorization into whose care the above mentioned minor has been entrusted, to consent to any x-ray examination, anesthetic, medical, surgical diagnosis or treatment and hospital care. Such care is to be rendered to said minor under the general or special supervision and upon the advice of a physician, dentist, and/or surgeon licensed to practice in the State Of Colorado and to consent to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care. In addition, I authorize Lafayette Recreation Department staff to exchange relevant information about my child. Every effort will be taken to locate a parent/guardian before any action is taken. All medical expenses will be accepted by the parent/ guardian. The Lafayette Recreation Department is absolved of any or all liability for accidents or injuries received during any or all program-sponsored activities.

_____ _____

Parent or Legal Guardian Signature Date

EMERGENCY INFO CARD

Child's Last Name	Child's First Name	Birth Date
Home Address		
City	Zip	Home Phone
Father's Name	Home Phone	Alt. Phone
Mother's Name	Home Phone	Alt. Phone
Emergency Contact	Contact Phone	Preferred Hospital
Physician's Name	Address	Phone
Dentist's Name	Address	Phone
Health Concerns, Allergies, etc.		

This "Emergency Info Card" is <u>VERY Important</u>! Your child's counselor will carry this card with them at all times. Please have <u>ALL</u> information filled in.

I give my permission to the recreation center staff to call a physician or emergency service for medical, dental or surgical care for my child should an emergency arise. I understand that all expenses incurred for the care of my child will be assumed by myself, I give recreation center staff complete authorization to speak for me and sign the necessary paperwork in order to gain medical care for my child. _____

Parent/Guardian Initials

Height: _____ Eye Color: _____ Weight: _____Hair Color: _____

Securely Tape A Recent "Head Shot" Photo Here

COLORADO LAW REQUIRES THAT THIS FORM BE COMPLETED FOR EACH STUDENT ATTENDING COLORADO SCHOOLS

Name _____ **Date of Birth** _____

Parent/Guardian _____

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT—CERTIFICATE OF IMMUNIZATION

Vaccine		Enter the month, day and year each immunization was given					
Hep B	Hepatitis B						
DTaP	Diphtheria, Tetanus, Pertussis (pediatric)						
DT	Diphtheria, Tetanus (pediatric)						
Tdap	Tetanus, Diphtheria, Pertussis						
Td	Tetanus, Diphtheria						
Hib	*Haemophilus influenzae* type b						
IPV/OPV	Polio						
PCV	Pneumococcal Conjugate						
MMR	Measles, Mumps, Rubella						
Varicella	Chickenpox			Healthcare Provider Documentation Date _____		Lab Verification Date _____	
Vaccines recorded below this line are recommended. Recording of dates is encouraged.							
HPV	Human Papillomavirus						
Rota	Rotavirus						
MCV4/MPSV4	Meningococcal						
Hep A	Hepatitis A						
TIV/LAIV	Influenza						
Other							

THIS SECTION CAN BE COMPLETED BY CHILD CARE/SCHOOL/HEALTH CARE PROVIDER

☐ **A) Child Care Up to Date**
Up to date through 6 months of age for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **B) Child Care Up to Date**
Up to date through 18 months of age for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **C) Child Care/Pre-school/Pre-K***
Up to date for Child Care/Pre-School/Pre-K for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **D) Complete for K–5th Grade**
Up to date for K–5th Grade for Colorado School Immunization Requirements — Update Signature _____ Date _____

* If age 4 years and fulfills Requirements for Pre-School & Kindergarten, check BOTH Boxes C and D.

HAS MET ALL IMMUNIZATION REQUIREMENTS FOR COLORADO SCHOOLS (6TH GRADE OR HIGHER)

Signed _____ Title _____ Date _____
(Physician, nurse, or school health authority)

STATEMENT OF EXEMPTION TO IMMUNIZATION LAW (DECLARACIÓN RESPECTO A LAS EXENCIONES DE LA LEY DE VACUNACIÓN)

IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS MAY BE SUBJECT TO EXCLUSION FROM SCHOOL AND TO QUARANTINE.
SI SE PRESENTA UN BROTE DE LA ENFERMEDAD, ES POSIBLE QUE A LAS PERSONAS EXENTAS SE LES PONGA EN CUARENTENA O SE LES EXCLUYA DE LA ESCUELA.

MEDICAL EXEMPTION: The physical condition of the above named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.
EXENCIÓN POR RAZONES MÉDICAS: El estado de salud de la persona arriba citada es tal que la vacunación significa un riesgo para su salud o incluso su vida; o bien, las vacunas están contraindicadas debido a otros problemas de salud.

***Medical exemption** to the following vaccine(s):*
***La exención por razones médicas** aplica a la(s) siguiente(s) vacuna(s):*

Signed (Firma) _____ Date (Fecha) _____
Physician (Médico)

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

RELIGIOUS EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a religious belief opposed to immunizations.
EXENCIÓN POR MOTIVOS RELIGIOSOS: El padre o tutor de la persona arriba citada, o la persona misma, pertenece a una religión que se opone a la inmunización.

***Religious exemption** to the following vaccine(s):*
***Exención por motivos religiosos** de la(s) siguiente(s) vacuna(s):*

Signed (Firma) _____ Date (Fecha) _____
Parent, guardian, emancipated student/consenting minor
(Padre, tutor, estudiante emancipado o consentimiento del menor)

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

PERSONAL EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a personal belief opposed to immunizations.
EXENCIÓN POR CREENCIAS PERSONALES: Las creencias personales del padre o tutor de la persona arriba citada, o la persona misma, se oponen a la inmunización.

***Personal exemption** to the following vaccine(s):*
***Exención por creencias personales** de la(s) siguiente(s) vacuna(s):*

Signed (Firma) _____ Date (Fecha) _____
Parent, guardian, emancipated student/consenting minor
(Padre, tutor, estudiante emancipado o consentimiento del menor)

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

Table 1. MINIMUM NUMBER OF DOSES REQUIRED FOR CERTIFICATE OF IMMUNIZATION

VACCINE [a]	Level of School/Age of Student											
	Child Care 2–3 mos	Child Care 4–5 mos	Child Care 6–7 mos	Child Care 8–11 mos	Child Care 12–14 mos	Child Care 15–18 mos	Child Care 19–23 mos	Pre-school 2–4 yrs	K Entry 4–6 yrs	Grades K to 5 5–10 yrs	Grades 6 to 12 11–18+yrs	College
Hepatitis B [l]	1	2	3						3	3	3	
Pertussis/Tetanus/ Diphtheria	1	2	3		see footnote b	4			5/4 [b]	5/4 [b c]	5/6 [c d]	
Haemophilus influenzae type b (Hib) [j]	1	2	2	3/2	3/2	3/2/1	3/2/1	3/2/1				
Pneumococcal Conjugate [k]	1	2	3/2		4/3/2	see footnote k						
Polio [e]	1	2	3						4/3 [f]	4/3 [f]	4/3 [f]	
Measles/Mumps/ Rubella [g]					1	see footnote g			2 [h]	2 [h]	2 [h]	2 [h i]
Varicella [m]					1	see footnote n			2 [n]	2/1 [n]	2/1 [n o]	
Meningococcal												[p]

a: Vaccine doses administered no more than 4 days before the minimum interval or age are to be counted as valid.

b: Five doses of pertussis, tetanus, and diphtheria vaccines are required at school entry in Colorado unless the 4th dose was given at 48 months of age or older (i.e., on or after the 4th birthday) in which case only 4 doses are required. There must be at least 4 weeks between dose 1 and dose 2, at least 4 weeks between dose 2 and dose 3, at least 6 months between dose 3 and dose 4 and at least 6 months between dose 4 and dose 5. The final dose must be given no sooner than 4 years of age (dose 4 may be given at 12 months of age provided there is at least 6 months between dose 3 and dose 4).

c: For students 7 years of age or older who have not had the required number of pertussis doses, no new or additional doses are required. Any student 7 years of age or older at school entry in Colorado who has not completed a primary series of 3 appropriately spaced doses of tetanus and diphtheria vaccine may be certified after the 3rd dose of tetanus and diphtheria vaccine (or tetanus, diphtheria, and pertussis vaccine if 10 or 11 years) if it is given 6 months or more after the 2nd dose.

d: The student must meet the minimum prior requirement for the 4th or 5th doses of diphtheria, tetanus, and pertussis vaccine and have 1 tetanus, diphtheria, and pertussis vaccine dose.

e: For polio, in lieu of immunization, written evidence of a laboratory test showing immunity is acceptable.

f: Four doses of polio vaccine are required at school entry in Colorado unless the 3rd dose was given at 48 months of age or older (i.e., on or after the 4th birthday) in which case only 3 doses are required. There must be at least 4 weeks between dose 1 and dose 2, at least 4 weeks between dose 2 and dose 3 and at least 6 months between dose 3 and dose 4. The final dose must be given no sooner than 4 years of age.

g: For measles, mumps, and rubella, in lieu of immunization, written evidence of a laboratory test showing immunity is acceptable for the specific disease tested. The 1st dose of measles, mumps, and rubella vaccine must have been administered at 12 months of age or older (i.e., on or after the 1st birthday) to be acceptable.

h: The 2nd dose of measles vaccine or measles, mumps, and rubella vaccine must have been administered at least 28 calendar days after the 1st dose.

i: Measles, mumps, and rubella vaccine is not required for college students born before January 1, 1957.

j: The number of Hib vaccine doses required depends on the student's current age and the age when the vaccine was administered. If any dose was given at 15 months of age or older, the Hib vaccine requirement is met. For students who began the series before 12 months of age, 3 doses are required of which at least 1 dose must have been administered at 12 months of age or older (i.e., on or after the 1st birthday). If the 1st dose was given at 12 to 14 months of age, 2 doses are required. If the current age is 5 years of age or older, no new or additional doses are required.

k: The number of pneumococcal conjugate vaccine doses depends on the student's current age and the age when the 1st dose was administered. If the 1st dose was administered before 6 months of age, the child is required to receive 3 doses 2 months apart and an additional dose between 12–15 months of age. If started between 7–11 months of age, the child is required to receive 2 doses, two months apart and an additional dose between 12–15 months of age. If the series was started between 12–23 months of age, then the child is required to receive 2 doses, two months apart. If the current age is 2 years of age or older, no new or additional doses are required.

l: For hepatitis B, in lieu of immunization, written evidence of a laboratory test showing immunity is acceptable. The second dose is to be administered at least 4 weeks after the first dose, and the third dose is to be administered at least 16 weeks after the first dose and at least 8 weeks after the second dose. The final dose is to be administered at 24 weeks of age (6 months of age) or older and is not to be administered prior to 6 months of age.

m: For varicella, written evidence of a laboratory test showing immunity or a documented disease history from a health care provider is acceptable. The 1st dose of varicella vaccine must have been administered at 12 months of age or older (i.e., on or after the 1st birthday) to be acceptable.

n: If the second dose of varicella vaccine was administered to a child before 13 years of age, the minimum interval between dose 1 and dose 2 is three months, however, if the second dose is administered at least 28 days following the first dose, the second dose does not need to be repeated. For a child who is 13 years of age or older, the second dose of varicella vaccine must have been administered at least 28 calendar days after the 1st dose. See Table 2 for the school years/grade levels that the 1st and 2nd doses of varicella will be required.

o: If the 1st dose of varicella vaccine was administered at 13 years of age, 2 doses are required, separated by a minimum of 4 weeks or 28 calendar days.

p: Information concerning meningococcal disease and the meningococcal vaccine shall be provided to each new student or if the student is under 18 years, to the student's parent or guardian. If the student does not obtain a vaccine, a signature must be obtained from the student or if the student is under 18 years, the student's parent or guardian indicating that the information was reviewed.

Table 2. TIMETABLE FOR IMPLEMENTATION OF REQUIREMENTS FOR SELECTED IMMUNIZATIONS FOR GRADES K TO 12

Refer to Table 1 for the minimum number of doses required for a particular grade level. Table 2 shows the year of implementation for a requirement from Table 1 and is restricted to varicella vaccine dose 1 (Var1) and dose 2 (Var2) and tetanus, diphtheria, and pertussis vaccine (Tdap). Requirements and effective dates for other vaccines are listed in Table 1. In this table, after a vaccine is required for grades K to 12, it is no longer shown, but the requirements listed in Table 1 continue to apply.

School Year	Grade Level												
	K	1	2	3	4	5	6	7	8	9	10	11	12
2007–08	Var2	Var1	Var1	Var1	Var1	Var1	Tdap Var1	Var1			Tdap		
2008–09	Var2	Var2	Var1	Var1	Var1	Var1	Tdap Var1	Tdap Var1	Var1		Tdap	Tdap	
2009–10	Var2	Var2	Var2	Var1	Var1	Var1	Tdap Var1	Tdap Var1	Tdap Var1	Var1	Tdap	Tdap	Tdap
2010–11	Var2	Var2	Var2	Var2	Var1	Var1	Tdap Var1	Tdap Var1	Tdap Var1	Tdap Var1	Tdap Var1	Tdap	Tdap
2011–12	Var2	Var2	Var2	Var2	Var2	Var1	Var1	Var1	Var1	Var1	Var1	Var1	
2012–13 (Var1 required for grades K to 12)	Var2	Var2	Var2	Var2	Var2	Var2	Var1	Var1	Var1	Var1	Var1	Var1	Var1
2013–14	Var2	Var2	Var2	Var2	Var2	Var2	Var2						
2014–15	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2					
2015–16	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2				
2016–17	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2			
2017–18	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2		
2018–19	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	
2019–20 (Var2 required for grades K to 12)	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2

Medication Administration in School or Child Care

The parent/guardian of _____ ask that school child care staff give the
(Child's name)
following medication_____ at _____
(Name of medicine and dosage) (Time(s))

to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

The Program agrees to administer medication prescribed by a licensed health care provider. It is the parent/guardian's responsibility to furnish the medication.
The parent agrees to pick up expired or unused medication within one week of notification by staff.

Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

Over the counter medication must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.

_____ _____ _____
Parent/Legal Guardian's Name Parent/Legal Guardian Signature Date

_____ _____
Work Phone Home Phone

****

Health Care Provider Authorization to Administer Medication in School or Child Care

Child's Name: _____ **Birthdate:**_____

Medication: _____

Dosage: _____**Route** _____

To be given at the following time(s): _____

Special Instructions: _____

Purpose of medication: _____ _____

Side effects that need to be reported:

Starting Date: _____**Ending Date:** _____

_____ _____
Signature of Health Care Provider with Prescriptive Authority **License Number**

_____ _____
Phone Number **Date**

Please ask the pharmacist for a separate medicine bottle to keep at school/child care.
Thank you!

Lafayette RECREATION

Allergy & Anaphylaxis Action Plan

Place child's photo here

Student's Name: _____D.O.B. _____ Grade: _____
School: _____ Teacher: _____

ALLERGY TO: _____

History: _____

Asthma: ☐YES ☐NO *Higher risk for severe reaction

To be completed by healthcare provider

◊ STEP 1: TREATMENT

SYMPTOMS: GIVE CHECKED MEDICATION(S)		
➢Suspected ingestion or sting, but *no symptoms*	☐Epinephrine	☐Antihistamine
MILD SYMPTOMS: Itchy mouth, few hives, mild itch, mild nausea/discomfort		☐Antihistamine
MOUTH Itching, tingling, or mild swelling of lips, tongue, mouth	☐Epinephrine	☐Antihistamine
SKIN: Flushing, hives, itchy rash	☐Epinephrine	☐Antihistamine
STOMACH Nausea, abdominal pain or cramping, vomiting, diarrhea	☐Epinephrine	☐Antihistamine
‡ THROAT Tightening of throat, hoarseness, hacking cough	☐Epinephrine	☐Antihistamine
‡ LUNG Shortness of breath, repetitive coughing, wheezing ☐ Inhaler	☐Epinephrine	☐Antihistamine
‡ HEART Weak or thready pulse, dizziness, fainting, pale, or blue hue to skin	☐Epinephrine	☐Antihistamine
➢If reaction is progressing (several of the above areas affected), give	☐Epinephrine	☐Antihistamine

‡ Potentially life threatening: give epinephrine first, then can give antihistamine!
Remember - severity of symptoms can quickly change!

DOSAGE

Epinephrine: inject intramuscularly (check one):
☐EpiPen®0.3 mg ☐EpiPen®Jr.0.15 mg
☐ Administer 2nd dose if symptoms do not improve in 15 – 20 minutes

Antihistamine: give_____
(Medication/dose/route

****ATTENTION..If Antihistamine given, the parents will be notified to pick up their child for closer observation!**

Asthma Rescue (if asthmatic): give_____
(Medication/dose/route)

Student has been instructed and is capable of self administering own medication. ☐Yes ☐No

Provider (print) _____Phone Number: _____

Provider's Signature: _____

Start Date: _____End Date:_____

◊ STEP 2: EMERGENCY CALLS :

If epinephrine given, **call 911.** State that an allergic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.

1. Parent: _____ Phone Number: _____
2. Emergency contacts: Name/Relationship Phone Number(s)
   a. _____1) _____ 2) _____
   b. _____ 1) _____ 2) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED; DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

I give permission for school and/or child care facility personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school and/or childcare facility with prescribed medication and delivery/monitoring devices. I approve this Severe Allergy Care Plan for my child. **This Health Care Plan will be effective for one year or unless parents and/or physician request to have changes made sooner**

Parent/Guardian's Signature: _____Date:_____

School Nurse: _____ Date: _____

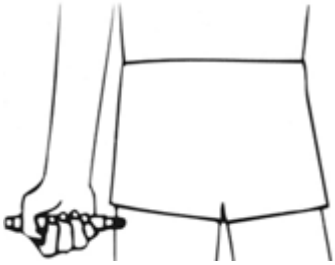
Student Name: _____ DOB: _____

EpiPen® and EpiPen® Jr. Directions

Expiration date: _____

- Pull off blue activation cap.

- Hold orange tip near outer thigh (always apply to thigh)



- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit CALL 911
- Student to remain lying done

Lafayette RECREATION

COLORADO SCHOOL ASTHMA CARE PLAN:

Photo of Child

NAME:	BIRTH DATE:
TEACHER:	GRADE:
PARENT/GUARDIAN:	CELL PHONE:
HOME PHONE:	WORK PHONE:
OTHER CONTACT:	PHONE:
PREFERRED HOSPITAL:	

Triggers: ☐Weather(cold air, wind) ☐ Illness ☐Exercise ☐Smoke ☐Dog/Cat ☐Dust ☐Mold ☐Pollen Other:_____

☐Give 2 puffs of _____rescue med ☐15 minutes before activity. Indications: ☐Phys Ed class ☐exercise/sports ☐Recess

Explanation:

☐Repeat in 4 hours if needed for additional or ongoing physical activity

YELLOW ZONE: SICK – UNCONTROLLED ASTHMA (Health provider complete dosing for rescue inhaler)	
IF YOU SEE THIS:	**DO THIS:**
• Difficulty breathing • Wheezing • Frequent cough • Complains of chest tightness • Unable to tolerate regular activities but still talking in complete sentences • Other:	• Stop physical activity • **GIVE RESCUE MED (NAME):_____** ☐ **1 PUFF** ☐ **2PUFFS** ☐ **OTHER:** ☐ **VIA SPACER** • If no improvement in 10-15 minutes, repeat use of rescue med: ☐ **1 PUFF** ☐ **2 PUFFS** ☐ **OTHER:** ☐ **VIA SPACER** • If student's symptoms do not improve or worsen, call 911 • Stay with student and maintain sitting position • Call parents/guardians and school nurse • Student may resume normal activities once feeling better
• **IF THERE IS NO RESCUE INHALER AT SCHOOL:** ➢ CALL PARENTS/GUARDIANS TO PICK UP STUDENT AND/OR BRING INHALER/MEDICATIONS TO SCHOOL ➢ INFORM THEM THAT IF THEY CANNOT GET TO SCHOOL, 911 MAY BE CALLED	
IF YOU SEE THIS: RED ZONE -SEVERE UNCONTROLLED ASTHMA	**DO THIS IMMEDIATELY:**
• Coughs constantly • Struggles or gasps for breath • Trouble talking (only able to speak 3-5 words) • Skin of chest and/or neck pull in with breathing • Lips or fingernails are gray or blue • ↓Level of consciousness	• **GIVE RESCUE MED (NAME):_____** ☐ 1 PUFF ☐2 PUFFS ☐ OTHER: ☐VIA SPACER • **Call 911 Inform attendant the reason for call is ASTHMA** • Call parents/guardians and school nurse • Encourage student to take slower deeper breaths • Stay with student and remain calm • *School personnel should not drive student to hospital*

INSTRUCTIONS FOR RESCUE INHALER USE: HEALTH PROVIDER: PLEASE CHECK APPROPRIATE BOX

☐Student has life threatening allergy, the EpiPen is located:_____

_____	_____	_____	_____
HEALTH CARE PROVIDER SIGNATURE	PLEASE PRINT PROVIDERS NAME	START DATE	END DATE

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our physician. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Care Plan for my child.

_____	_____	_____	_____
PARENT SIGNATURE	DATE	SCHOOL NURSE SIGNATURE	DATE

Copy of plan provided to: ☐ Teachers ☐ Phys Ed/Coach ☐ Principal ☐ Main Office ☐Bus Driver ☐ Other ☐ 504 Plan or IEP

B.A.S.E. After School Program
Emergency Information Forms

* All areas must be filled in, if not applicable write N/A.

SUNSCREEN PERMISSION FORM

Children will apply sunscreen to themselves under the direct supervision of a staff member 15-30 minutes before outdoor activities. The staff will assist children only when needed to bare surfaces upon request. Sunscreen will not be applied to any broken skin or if a skin reaction has been observed. Any skin reaction observed by staff will be reported promptly to parent/guardian. It is the parent's responsibility to provide sunscreen with a specific amount of SPF they wish their child to have. Please have your child's first and last name clearly labeled on the bottle. BASE After School staff will be using Coppertone Sport with SPF 30.

_____ I do not want my child to use any sunscreen other than the one I will provide. The sunscreen I provide will be clearly marked with my child's name.

_____ _____

Child's Name Parent or Legal Guardian Signature

INSECT REPELLENT PERMISSION FORM

There may be times during the summer when we will need to use insect repellent. We will use OFF or Cutter products with concentrations of 10% or less of DEET. The program staff will provide the insect repellent and apply it to the children.

_____ I do not want my child to use any insect repellent other than the one I will provide. The insect repellent I provide will be clearly marked with my child's name.

_____ _____

Child's Name Parent or Legal Guardian Signature

A NUTRITIOUS LUNCH ~ FOR FULL DAY PROGRAM DATES

The Colorado State Department of Childcare Licensing (7.702.65 Food and Nutrition) requires that all children who are at the BASE After School Program for 4 or more hours receive a meal that meets one-third of the child's daily nutritional needs. The requirement must be met regardless of whether the program or the parent provides the lunch. Staff will be checking lunches provided by parents to make sure the requirement is met. If a child does not have a snack and lunch or if the program needs to supplement a child's snack and lunch to meet the requirement, the parent will be charged a fee of up to $10.00 for each instance.

I understand that my child will need two nutritious snacks and sack lunch with a drink on all ***full days*** unless otherwise notified. I understand that if my child does not bring a snack and lunch or if the lunch does not meet the nutrition guidelines as stated in the State of Colorado Childcare Licensing Rules and Regulations, I may be charged a fee for supplementing or supplying my child's lunch.

_____ _____

Parent or Legal Guardian Signature Date

B.A.S.E. After School Program
Emergency Information Forms

* Payment, Policy & Procedures, Waivers Agreement

_____ I understand payment is due on or before the 1st of each month. I further understand if payment is not received by the 2nd, my child's placement will be forfeited and the $25.00 deposit is NON-refundable. These payments may be made online.

_____ I understand the BASE After School Program reserves the right to refuse service to anyone who has a delinquent balance on their household account.

_____ I understand there is a $5.00 transfer fee and all transfers must be made two weeks in advance.

_____I understand if I choose to cancel my child's enrollment a written 30 day notice is required and the registration fee is non-refundable. The pre-paid last month's payment will be applied to my child's last month of attendance. If written notice is given in less than 30 days, a 25% cancellation fee will be charged on the last month's pre-paid payment and the current month will not be refunded.

_____ I have read and understand the parents' manual in its entirety and I am familiar with all the policies and procedures.

_____ I understand the BASE After School Program reserves the right to refuse service and terminate care based on excessive behavioral issues.

_____ I understand the BASE After School Program is not liable or responsible for my child before he/she is signed in or after he/she has been signed out.

_____ I understand the BASE After School Program is not responsible for lost, stolen or damaged items. Please do not send your child with valuable items, i.e. cell phone, iPods, money, or mp3 players.

_____ I understand my child will need a nutritious sack lunch with a drink and two snacks on *full day program dates*, unless otherwise notified. I understand if my child does not bring a lunch or snacks or if the lunch does not meet the nutrition guidelines as stated in the State of Colorado Child Care Licensing Rules & Regulations, I may be charged a fee of up to $10.00 for each instance the staff needs to supplement or supply my child with a lunch or snacks.

_____ I understand if my child will not be attending the program for any reason on a scheduled day, it is my responsibility to ask the staff, for an "absence form". I will fill out this form and submit to staff in advance of the change in schedule. In emergency situations I will call the program directly and notify them of my child's absence. No credit will be given for absences.

_____ I understand the BASE After School Program staff are discouraged from watching children outside of the program.

_____ I give the BASE After School Program permission to take my child on any field trip away from the camp location for which advance notice has been given.

_____ I give the BASE After School Program permission to take appropriate photographs of my child during program activities to be displayed within the program or for promotion of the program.

_____ I give permission for my child to participate in all of the activities offered at the BASE After School Program. If there are any activities you do not wish your child to participate in please list them here:

_____

_____ I give permission for my child to be transported from the BASE location to the scheduled destination when needed.

B.A.S.E. After School Program
Emergency Information Forms

* All areas must be filled in, if not applicable write N/A.

A description of your child's behavior and reaction to various incidents is desired. This information is confidential and will be reviewed by the BASE staff as a key to working with your child as an individual member of our program.

Interaction with males: _____
Interaction with females: _____
Fears and dislikes: _____
Types of discipline used at home: _____
Reward system used at home: _____
Positive/negative school / camp experiences: _____
_____
Child's favorite activity/hobbies/interest:
_____

Briefly comment on the following:

Athletic ability: _____
Coordination: _____
Play skills: _____
Peer interactions: _____
Additional comments on child's social history: _____

Does your child:

Wear: glasses ____ Yes _____ No
Hearing aid ____ Yes _____ No
Need assistance walking ____ Yes _____ No
Need assistance with toileting ____ Yes _____ No
Use a wheelchair ____ Yes _____ No
Feed self ____ Yes _____ No
Dress self ____ Yes _____ No
Use scissors, crayons, paint, paste, and small objects:
_____ well ____ adequately ____ not at all
Communication abilities: How does your child make her/his needs known?
_____
Does your child currently have any emotional or behavioral problems? YES NO
Does your child prefer to play alone? YES NO
Name and ages of siblings:
_____
If your child has special needs:
Diagnosis:
_____

Swimming Permission Form:

Please rate your child's swimming abilities below to help ensure their safety while at the pool.
Cannot Swim (Kiddy Pool Area only): _____
Can swim / play in shallow water (intermediate): _____
Swims well (advanced): _____
Special instructions: _____

PLEASE FEEL FREE TO DISCUSS ANY SOCIAL OR BEHAVIORAL CONCERNS YOU MAY HAVE WITH THE RECREATION SUPERVISOR.

B.A.S.E. After School Program Expectation Agreement

This agreement states expectations of the student while attending BASE. Please read through this contract with your child. All students are held responsible for the choices they make at BASE. Please initial each line (one for student, one for parent) and sign at the bottom.

STUDENT	PARENT	
_____	_____	I will do my personal best to have a great experience during the BASE After School Program!
_____	_____	I will treat all participants and staff with respect, so they will know how to treat me.
_____	_____	If I cause a problem I will solve it, if I can't solve the problem, or choose not to, a BASE staff member will step in to assist with the situation.
_____	_____	I will behave in ways that secure the safety of others and myself. (This includes, but is not limited to: NO abusive language, "play" wrestling, kicking, hitting, theft, bullying, etc.)
_____	_____	I will follow instructions given by BASE staff and program supervisors.
_____	_____	If I feel something is unfair, I will calmly talk to a BASE staff or program supervisor about it.
_____	_____	I understand what a BASE staff or program supervisor decides to do concerning discipline will depend on each person and each situation.
_____	_____	I understand I am not to bring any personal belongings to the BASE program or full day program dates (i.e., toys, collector cards, game boys, mp3 players, money, etc.). I understand that if I bring personal belongings to BASE the BASE staff or program supervisors have the right to take the item (s). (Items will be given back at the end of the day). BASE staff are not responsible for these if lost or stolen.
_____	_____	I will respect all BASE equipment and facilities.
_____	_____	I will be an active and positive participant during activities.

By signing this agreement, you state that you have read and agree to the terms of the agreement. Not following this agreement, may lead to disciplinary action and ultimately, removal from the BASE After School Program.

_____ _____

Student Signature Parent or Legal Guardian Signature

B.A.S.E. After School Program
Emergency Information Forms

* All areas must be filled in, if not applicable write N/A.

TRANSPORTATION PERMISSION FORM

Children may be transported by means of different transportation systems indicated below.

Destination: (Flyers with specific locations will be handed out in advance of each After School or Full Day Field Trip)
Transportation will be by:

X Walking **X** City Bus and/or Van **X** BVSD School Bus

_____ _____
Parent or Legal Guardian Signature Date

CODE OF CONDUCT AGREEMENT

Every person that enrolls in our BASE After School Program, including the BASE personnel, is a potential role model for the children present. As role models we are ALL expected to portray citizenship, kindness, respect for all, positive communication, problem solving behaviors, and appropriate regard of property.
Per State law, smoking, drug and/or alcohol use are never permitted. If suspected abuse occurs, the person(s) involved will be subject to removal from city facilities.
UNRESOLVED ISSUES:
To address unresolved issues, a meeting may be planned to discuss the matter. In the event a solution can not be reached between the staff and the parent/guardian, a third party intervention may be requested. Parents may contact the following: Karen Snortland, Recreation Supervisor and/or Kathy Apjoke, Recreation Specialist at 303-665-0469.

I understand and agree to adhere to the "Code of Conduct Agreement"

_____ _____
Parent or Legal Guardian Signature Date

_____ _____
Student Signature Date