Options Infant Center
Enrollment Application

Date of Enrollment (start date):_____

Child's Full Name:_____

Home Address:_____

(Street) (City) (Zip Code)

D.O.B.:____/____/____ M / F Age:_____

Phone Number:_____

Parent Information

Mother's Full Name:_____ Age:_____

Home Address:_____

(Street) (City) (Zip Code)

Phone Number:_____ Cell/Work Phone:_____ E-mail_____

Employer:_____Position:_____

Work Address:_____

(Street) (City) (Zip Code)

Father's Full Name:_____ Age:_____

Father'sAddress:_____

(Street) (City) (Zip Code)

Phone Number:_____ Cell/Work Phone:_____ E-mail_____

Employer:_____Position:_____

Work Address:_____

(Street) (City) (Zip Code)

Instructions for Reaching Parents: _____

I authorize the following individual/s to pick up my child:

Name	Relation	Address	Home Phone	Work/Cell Phone

Emergency Contact: (other than Parents)

Name	Relation	Address	Home Phone	Work Phone	Cell Phone

Authorization for Infant Center Participation

Please review all statements below. By initialing the statement I am agreeing to the following:

_____ I give permission for my child to leave the center premises under staff supervision for any walking (in a stroller) excursion for which I have been notified of in advance.

_____ I give hereby acknowledge that I have received and read a copy of the **Options Infant Center Handbook** and agree to abide by the policies outlined there. I further acknowledge that these are subject to change at the discretion of the Options Infant Center staff and Options High School Administrators. Furthermore, I agree to pay the parent co-pay as described in the Handbook. I understand that my child may be suspended or expelled from the program if these policies are not followed as outlined within the handbook.

_____I have also received and read the **CCAP policies** (ONLY for teen parents) that are listed in the back of the Parent Handbook as well as the CCAP Policy Contract. Furthermore, I agree to pay the parent co-pay as described in the policies. I understand that my child may be suspended or expelled from the program if these policies are not followed as outlined within the handbook and contract.

PARENT/GUARDIAN AUTHORIZATION:

I have reviewed the procedures and rules for the Options Infant Center Program. I understand that all co-pay fees are non-refundable. The information provided on this form is correct so far as I know, and the child herein described has my permission to engage in all prescribed daily activities , except noted by me and the examining physician.

When a child is injured or ill and required immediate medical attention, the Fire Department Paramedics will be called. If a parent or guardian cannot be contacted, we, the undersigned parents of the child identified herein, authorize officials of the Littleton Public School District to contact directly the physician(s) of our selection. We authorize the Paramedics or physician named herein to render such treatment as said Paramedics or physician or either of them, deem reasonably necessary in an emergency. Following emergency treatment by paramedics, in the event the physician herein named cannot be contacted, or either of us in unavailable to give our express consent at such time with reference to any other physician, we hereby consent and authorize the officials of the Littleton Public School District to contact any licensed physician. We hereby authorize said physician to render such treatment as may be deemed reasonably necessary, in what may be considered to be an emergency, for the health of our aforesaid minor child. Expense incurred as a result of emergency ambulance use or treatment by physician will not be borne by the school or school personnel.

*Parent/Guardian Signature*_____ *Date*_____

Medical Information

Child's Name_____ **Date of Birth**_____

Child's Doctor:_____ Phone Number:_____

Address:_____

(Street) (City) (Zip Code)

Hospital of Choice:_____ Phone Number:_____

Address:_____

(Street) (City) (Zip Code)

Child's Dentist:_____ Phone Number:_____

Address:_____

(Street) (City) (Zip Code)

Insurance Company:_____ Policy #_____

Health History

Please provide the following so that we can be aware of your child's needs. Any changes to this form should be given to the Nursery Supervisor.

ALLERGIES (list all known. Describe reaction and management of reaction)

Medication allergies

_____ _____

Food allergies

_____ _____

Other allergies- include insect stings, hay fever, asthma, animals, ect.

_____ _____ _____

Any specific information we should know?

_____

_____

Surgery/Accidents/Illness/Chronis Health Concerns:

_____

_____

Please describe any physical conditions which require special care:

_____

_____

MEDICATIONS BEING TAKEN

Please list ALL medications taken routinely. Please state the name of the medications, dosage, and the frequency of administration.

_____This child does NOT take any medication on a routine basis

_____This child DOES take medication on a regular basis. *If marking this statement, please contact the Learning Center Director at 303.347.3593 for additional required information.*

Please list ALL medications taken routinely even medications not dispersed while the child is in care. This information is needed if the child needs medication attention.

Medication #1: _____ Dosage_____ Times Taken_____
Reason for taking_____

Medication #2: _____ Dosage_____ Times Taken_____
Reason for taking_____

Is there any additional; information regarding medication?

_____

_____

****Please provide a current copy of the child's immunization record.****

Parent/Guardian Authorization: This health history is correct and complete as far as I know, and the child described herein has permission to engage in all daily activities except as noted.

_____ _____
(Signature Parent or Guardian) (Date)

BLANKET MEDICATION PERMISSION FORM

Child's Name: _____ Date:_____

While in the Nursery, medication can be administered by Infant Center Staff or parent ONLY. This medication is for preventative uses only, and is in the form of diaper cream ONLY. Blanket Medication will not be applied to any broken skin or if a skin reaction has been observed. Any skin reaction observed will be reported promptly to parent/guardian All blanket medication is to be supplied by the parent/guardian and labeled with the child's first & last names.

_____I give permission for Options Infant Staff to apply the following cream on my Child._____

_____I do NOT want blanket medication applied on my child.

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

MEDIA RELEASE

Child's Name: _____

I give permission to feature my child and his/her work in the following ways without compensation:

Please initial all of the following which apply:

_____I give permission for my child to be photographed, or videoed for stories/articles promoting Options High School, the Options Infant Center Program, and the Littleton Public School District. These stories may appear in the newspaper or on television. I give consent for the release of the photographs/videotapes to the media in school related coverage.

_____I give permission for my child's photo, and/or video tape to be used only in Options Infant Center activities. (must be initialed to participate in Teaching Strategies Gold)

_____I give permission for my child's photo to only be displayed in the Options High School yearbook.

_____I give permission for my child's photo and work to be displayed on district and/or school web sites.

Support Pacifier Use

New safe sleep practices have been implemented as of April 2015. One of the new requirements is to use a support pacifier for infants one month of age or older. A support pacifier is recommended to protect the possibility of infants overheating during sleep.

_____I give permission for Options Infant Center staff to offer my child a pacifier during normal sleeping routines.

_____I **DO NOT** want my child to be offered a pacifier during sleeping routines.

_____ _____

Parent's Signature Date

SUNSCREEN PERMISSION FORM

Sunscreen will be applied to children 6 months and older prior to any outside activities and throughout the day by Options Infant Center staff members and volunteers. 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. The Options Infant Center will be using ***COPPERTONE: WATER BABIES SPF #50.***

***Child's Name*_____**

_____I give my permission for the Options Infant Center staff and volunteers to apply the above named sunscreen on my child.

_____I will be providing my own sunscreen for the Options Infant Center staff members and volunteers to apply to my child. I am providing: _____

_____Do not apply sunscreen to my child under any circumstances.

_____ _____

Parent/Guardian's Name Parent/Guardian Signature

Teen Parenting/Child Development Class Lab Permission

(Does not apply to Teen Parents)

Child's Name:_____ Date:_____

On occasion the Teen Parenting Class and/or Child Development class at Options High School may come into the Options Infant Center. During the student's time in the classroom, they may engage in activities with the children. These activities have been planned with the Teen Parenting teacher and the students along with all activities are overseen by the Learning Center staff and Teen Parenting teacher.

_____ I give permission for my child to engage with the students and their activities during the lab time in the Learning Center.

_____I **DO NOT** give permission for my child to engage with the students and their activities during their lab time in the Learning Center.

_____ _____

Parent's Name (Print) Parent's Signature