To attend **Project Denver** FREE of charge turn in the following completed forms by_____ to your school or agency contact.

1. Emergency Information/Registration Form
2. Child Abuse Policy
3. Health Consent Form
4. General Health Appraisal Form (physical)---**signed by doctor**.
5. Attach a copy of your child's current VACCINATION RECORD

All forms must be turned in to reserve a spot at camp

Where: Carson Elementary:
5420 E. 1st Avenue, Denver, CO 80220

When: July 2nd, 3rd, 5th and 6th

We will provide:

FUN!!! A great camp experience!
Lunch & Snacks

Please send your child to camp with:

A backpack containing:
Water Bottle
Swimsuit & Towel & Sunblock
Water Shoes – optional

For more information or with questions please call:
Katie 720-217-3075 • Jill 303-589-9330

KEEP THIS PAPER AS YOUR REMINDER.

EMERGENCY INFORMATION & AUTHORIZATION FORM

Child's Name _____
(Last) (First) (Birthdate) (Boy/Girl)

Parent/Guardian Names _____
(Relation to child)

Address _____
(Street/Apt No.) (City) (Zip)

Phone Numbers _____
(Home) (Work) (Cell)

Other family members attending Project Denver: _____

I hereby grant permission for my child to use all of the equipment provided by staff on the campus and to participate in all activities at Project Denver.

I hereby grant permission for the person in authority to take whatever steps may be necessaryto obtain emergency care if warranted. These steps include, but are not limited to, the following:

1. Attempt to contact parent or guardian.
2. Attempt to contact the child's physician.
3. Attempt to contact emergency persons listed below.
4. Call an ambulance or paramedic.
5. Take my child for treatment to any doctor or any hospital in the company of a staff member.

HOSPITAL OF CHOICE: _____

ANY EXPENSES WILL BE INCURRED BY THE CHILD'S FAMILY.

INSURANCE INFORMATION

Name of Insured: _____

Insurance Co: _____

I.D.#: _____ Policy #: _____

EMERGENCY CONTACTS

Child's Physician: _____
(Phone)

Child's Dentist: _____
(Phone)

In the event you are unavailable, please list two emergency contacts:

Name: _____
(Phone)

Name: _____
(Phone)

ONLY THE FOLLOWING PEOPLE ARE ALLOWED TO PICK UP MY CHILD Include parent/guardian names that will pick child up.

Name: _____
(Phone)

Name: _____
(Phone)

Name: _____
(Phone)

Name: _____
(Phone)

Parent or Legal Guardian Signature: _____
(Date)

Email Address: _____

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.

Dear Parents,

The purpose of this letter is to inform you of the Colorado policy regarding the reporting by public or private schools (or summer camps) of any incidence of suspected child abuse. Please sign and return to Project Denver by May 15, 2018.

Summer Camp Policy regarding Reporting Suspected Abuse:

In accordance with Colorado Children's Code law 19-3-304, a camp employee "who has reasonable cause to know or suspect that child has been subjected to abuse or neglect or who has observed the child being subjected to circumstances or conditions which would reasonably result in abuse or neglect" is required to make a report to the Department of Social Services.

Any counselor who has any knowledge or suspicion that a child has been subjected to abuse or neglect is required to file a report with the Department of Social Services, or to consult with the Camp Director who will file a report on behalf of the school.

Information about the case will be handled confidentially and will not be given to other counselors or parents. The identity of the counselors who report such information will not be given to other counselors or to parents.

I have read and understand the Colorado State Law regarding the reporting of suspected child abuse. I understand that the staff of Project Denver is required to follow the stated law.

Child's Name:

_____

(Date of Birth)

Parent Signature:

_____

(Date)

HEALTH CONSENT FORM

The undersigned parent/legal guardian of _____
Camper's Name

I hereby request that my child be given the following medication for cuts, fever, pain, swelling, or itching. My child is not allergic to these medications nor has he/she had any adverse reaction to them. I therefore give my consent to administer them as needed.

Neosporin Ointment
Bacitracin Ointment
Children's Advil – 100mg every 6-8 hours
Children's Tylenol – 80mg every 4 hours
Children's Benadryl – 12.5 mg every 4-6 hours

Parent/legal guardian signature _____Date_____