COLORADO CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com

COLORADO
Department of Public Health & Environment

This form is to be completed by a health care provider (physician (MD, DO), advanced practice nurse (APN) or delegated physician's assistant (PA)) or school health authority. School required immunizations follow the ACIP schedule. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at 6th grade entry.

Student Name: _____ Date of birth: _____

Parent/guardian: _____

Required vaccines

	Immunization date(s) MM/DD/YY							Titer date* MM/DD/YY
Hep B Hepatitis B								
DTaP Diphtheria, Tetanus, Pertussis (pediatric)								
Tdap Tetanus, Diphtheria, Pertussis								
Td Tetanus, Diphtheria								
Hib *Haemophilus influenzae* type b								
IPV/OPV Polio								
PCV Pneumococcal Conjugate								
MMR Measles, Mumps, Rubella								
Measles								
Mumps								
Rubella								
Varicella Chickenpox								

Varicella - date of disease		Varicella - positive screen date		*A positive laboratory titer report must be provided to the school to document immunity.

Recommended vaccines

	Immunization date(s) MM/DD/YY						
HPV Human Papillomavirus							
Rota Rotavirus							
MCV4/MPSV4 Meningococcal							
Men B Meningococcal							
Hep A Hepatitis A							
Flu Influenza							
Other							

Health care provider signature or stamp: _____ Date: _____

Student is current on required immunizations for age (circle one): Yes No

OR

Immunization record transcribed/reviewed by school health authority:

School health authority signature or stamp: _____ Date: _____

(Optional) I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____

Last Reviewed: December 2017

Springboard
EDUCATE | ENGAGE | EMPOWER

General Health Appraisal Form
PreS-PreK (ages 3 & 4) ONLY

Parent/Guardian: Complete top section and give this form to your child's health care provider for completion.

Child's Name: _____ Gender: _____ DOB: _____

Allergies: ☐ None known / ☐ Describe: _____

Type of Reaction: _____

I, _____ give consent for my child's health provider, school or childcare personnel to discuss my child's health concerns. My child's health care provider may email this form (and applicable attachments) to my child's childcare provider.

_____ Date: _____
Parent or Legal Guardian Signature — Authorization expires 365 days after this date

Health Care Provider: Please complete all remaining sections of this form. Attach additional information if needed.

Date of Last Exam: _____ ☐ NORMAL ☐ ABNORMAL

Weight _____ Height _____ Blood Pressure _____ Lead Level _____

Significant Health Concerns: ☐ None ☐ Reactive Airways Disease ☐ Seizures ☐ Diabetes ☐ Developmental Delays ☐ Vision ☐ Hearing ☐ Severe Allergies ☐ Other _____

Explain above concerns (if necessary, include instructions to childcare providers): _____

_____

Current Medications/Special Diet: ☐ None ☐ Describe: _____

_____
(Separate medication authorization form required for medications given in child care)

Immunizations: ☐ Up-to-date ☐ See attached immunization record ☐ Administered today: _____

_____

Next Well Visit: ☐ Per AAP Guidelines or ☐ Age _____

This child is healthy and may participate in all routine activities, sports, camps and child care. Any concerns or exceptions are identified on this form.

_____ _____
Signature of Health Care Provider (certifying form was reviewed) — Date

Springboard Authorizations Form 2019-20

Enrollment Information: I have read and understand the enrollment information on admission and tuition. Initial _____

Updated Child's Records: I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g., telephone numbers, work location, emergency contacts, child's physician, child's health status and immunization records, etc. Initial _____

Hospital Transportation: In case of medical emergency I give permission for Springboard to release my child and to be transported to a hospital. My preferred hospital is:
(Name of Hospital) _____

(Hospital Address) _____

(Hospital Phone Number) (_____)_____ or to the nearest hospital by ambulance subject to the EMT's authority once child has been released to their care. Initial _____

Child's Dentist: _____

Dentist's address: _____

Dentist's phone: _____

First Aid/CPR: I give permission for Springboard staff to administer First Aid & CPR to my child, if necessary. Initial ____

In the event of an emergency: I give Springboard permission to act on my behalf and provide needed medication and assistance. Initial ____

Video/Picture Permission Slip - External: I give permission and consent for Springboard to take pictures/video of my child during program hours and activities. I further give permission and consent that any such photographs/video may be published and used by Springboard Education in America and its agents to illustrate and promote the Springboard experience on **Springboard's website, social media, or for the purpose of brochures and advertisements.** Initial ___

Video/Picture Permission Slip – Internal: I give permission for Springboard to take pictures/video of my child during program hours and activities to be used for **internal purposes posted at Springboard site, Class Dojo and/or Shutterfly.** Initial ___

Release of Records: I authorize Springboard to access and review all health and educational records on file with my child's school, for the purposes of providing a safe, healthy environment that supports my child's academic growth and achievement. This data may include, but is not limited to, an IEP, disability evaluations and test data. Springboard adheres to the highest levels of confidentiality when accessing information contained in these records. Initial _____

Medications: I understand that in order for my child to be given medications (prescriptions and/or over the counter medications), I must provide written authorization by the physician and parent. Medication must be provided in the original bottle with an original label. Initial _____

Sunscreen: I give permission for Springboard to apply sunscreen to my child if assistance is needed. I will supply the sunscreen in its original bottle to you clearly labeled with my child's name. Initial _____

TV/Video: I give permission for my child to use or view TV and or video games during their time at Springboard. I understand that the site coordinator monitors all TV exposure and videos. Initial _____

Parent Agreement: The child named on this form is "awesome," but I understand that children who behave in a "not-so-awesome" way can get sent home from their program without a refund. Initial _____

Springboard Authorizations Form 2019-20

I have read and initialed the above Authorizations and Policies

Parent Signature _____ Date _____

Print Parent Name _____

Print Child Name_____

All students must have a completed form on file in order to attend the Springboard Program. Please return your completed form to the Springboard Program at your child's school.