



Teddy Bear Preschool Center

Dolores School District

1550 Hillside Avenue (PO Box 727)

Dolores, CO 81323

970-882-7277

970-882-7922 Fax

970-739-4244 Valiena Cell

2024-2025

All New Families must turn in the following documents with no missing pieces by the first day of school:

Birth Certificate

Immunization Record

Current Physical

Copy of Child's Medical Insurance Card

All Returning Families must turn in a Current Physical with this packet to complete enrollment

Child's Full Name:
Date of Birth:
Date Packet Received:
Additional Comments:

***** All 4 and 5 year olds enrolled MUST be Potty Trained as we do not have the extra staff or diaper changing facilities in preschool classrooms.**

CHILD'S FULL NAME _____ D.O.B _____ PY: 24/25

EMERGENCY CONTACTS/AUTHORIZED CHILD PICKUP

Emergency contact persons are contacted in the event of an emergency, illness or injury. We must have a valid phone number for all emergency contacts listed. Authorized pick-up persons should be prepared to show picture identification to center staff. These contacts must be kept up to date throughout the year. **WE WILL RELEASE YOUR CHILD ONLY TO THE ADULTS FOR WHOM AUTHORIZATION HAS BEEN GIVEN.**

Parent/Guardian Names	Authorized to pick up? (Circle One)		OK to give information about my child? (Circle One)	Relationship to Child	Phone Numbers <i>*At least one phone number per contact is required</i>
	YES	NO			
1.			YES		1.Primary 2.

Email Address: _____ Physical Address _____

Parent/Guardian Names	Authorized to Pick Up? (Circle One)		OK to give information about my child? (Circle One)	Relationship to Child	Phone Numbers <i>*At least one phone number per contact is required</i>
	YES	NO			
2.			YES		1.Primary 2.

Email Address: _____ Physical Address _____

*****IF NEEDED, the child will be taken to Southwest Memorial Hospital... 970-565-6666.**
CONSENT TO TREAT: In the event of a medical emergency involving this child, I hereby give Teddy Bear Preschool permission to render emergency aid including, but not limited to, having him/her transported for care by a doctor if any of the above cannot be contacted. Any member of the staff responsible for the care and education of my child may view my child's health information, as well as state licensing for compliance purposes.

Parent/Guardian Signature _____ Date _____

Family Physician _____ Child's Dentist _____

Physician's Phone# _____ Dentist Phone # _____

Additional Emergency Contacts: Please list at least one, if possible

Name (First and Last)	Authorized to Pick up (Circle One)		OK to give information about my child?		Relationship to Child	Phone Numbers
	YES	NO	YES	NO		
1.						
2.						
3.						
4.						
5.						
6.						

***Additional Notes or Special Instructions (Custody Details, Restraining Orders, etc):**

NOTE: You are required to give Teddy Bear Preschool a copy of the LEGAL DOCUMENTS pertaining to child custody. The school will presume that both parents on the BIRTH CERTIFICATE have equal access to the child when that student is registered in school UNLESS one parent provides the school with OFFICIAL CUSTODY COURT PAPERS.
 Your signature grants approval to the following statement: " I hold Teddy Bear Preschool harmless from any liability in releasing my child to the signed authorized pickup or myself."

Parent/Guardian Signature: _____ Date: _____

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Place of Birth _____

Mailing Address _____

Physical Address _____

Home Phone _____ Work Phone _____ CellPhone _____

Email Address _____

Attendance: (Check One) Morning Only _____

Full Day _____

Circle requested days: Mon. Tues. Wed. Th.

(Minimum 2 days)

FAMILY INFORMATION

The following requested information is used to assist in (1) determining eligibility for funded slots and (2) data requested for grant/demographics.

Please list all children and adults living in the household:

Name	Age	Relationship to Child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(If additional space is needed, please continue on the back of this page)

Father's Name _____ **Birth Place** _____

Birth date _____

Address (if different than child) _____

Employer name and phone# _____

Mother's Name _____ **Birth Place** _____

Birth date _____

Address (if different than child) _____

Employer name and phone # _____

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***Marital status of parent (s) in the household (please check):**

single, never married married widower
 separated/divorced remarried

***Custody**

Who has legal custody of the child? Mom Dad Other
(If **Other**, we are required to have a copy of legal custody orders)

***Education of Parents (please circle):**

Mother: K 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 16+

Father: K 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 16+

***Which of the following resources are being used by your family?**

Help from extended family in your community
 Case worker from a social agency
 Other community resources (ex: job training, prenatal care, continuing education,
vocational services, recreational services)
 Other-please specify _____

***Which of the following are current family situations? (check all that apply)**

Transportation
 Health/Medical problems
 Marriage/Relationship problems
 Unemployment
 Housing

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Please check which insurance coverage you have on your child:

Medicaid _____	Child's Policy #: _____
CHP _____	Child's Policy#: _____
Indian Health _____	Child's Policy#: _____
Private Insurance _____	Child's Policy#: _____
None _____	

AGENCIES INVOLVED WITH YOUR FAMILY:

____ Public Health
____ WIC
____ Social Services
____ Other

IMMUNIZATION REGISTRY NOTICE: Your child's shot information is being entered in the Colorado Immunization Information (CIIS), a confidential, statewide immunization record tracking system. You can choose to exclude your child's shot information from the CIIS at any time. Please ask your school nurse or your health care provider for further information.

LANGUAGES SPOKEN BY THE FAMILY IN THE HOME (CHECK ALL THAT APPLY):

____ English
____ Spanish
____ Native American
____ Other-Please Specify _____

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HEALTH SCREENING QUESTIONNAIRE

Child's Full Name _____ Date of Birth _____

Gender: M__ F__

Name of person providing this information: _____

Relationship to child: _____

1. Has there ever been a concern about the age at which your child began (check all that apply):

Crawling__ Walking__ Talking__ Bowel or Bladder training__

2. Are there any major health problems in the family? No__ Yes__

3. Does your child have any chronic health conditions? No__ Yes__

Circle all that apply:

Diabetes Asthma Allergies Seizure Disorder Nervous Disorder

Ulcers Bronchitis Frequent Ear Infections Frequent Strep Infections

Heart Condition

If you checked yes to any of the above:

a) is he/she under treatment? No__ Yes__

b) can the school health services be helpful? No__ Yes__

If so, please comment _____

4. Has your child had any problems with vision? No__ Yes__

Has your child had any problems with hearing? No__ Yes__

If so, please comment: _____

5. Is your child on any medication? No__ Yes__

If yes, and this medication is to be administered at school, it will be necessary for you to complete a Release Form (to be signed by the child's physician).

6. Does your child have any special needs/disabilities? No__ Yes__

If yes, please explain: _____

7. Does your child have a **HEALTH CARE PROVIDER DIAGNOSED** food allergy, insect sting allergy or any other allergy? _____ (**PLEASE**, let staff know **before** school year starts)

If yes, please explain: _____

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PARENT CONTRACT FOR TUITION PAYMENTS

I _____, the parent/guardian of _____
Understand and Agree to the following:

Tuition charges at Teddy Bear Preschool are as follows:

Half Day	\$25.00 per day, Monday through Thursday
Full Day	\$40.00 per day, Monday through Thursday

***You will be charged tuition for each day that you have scheduled your child to be in attendance even if your child is absent.**

***Tuition fees are due by the 30th of each month.** Payments can be made weekly, bi-monthly, or monthly. Please circle your intended time of payment.

***A two week notice is to be given prior to the withdrawal of the child from the program.**

***A late fee of \$1.00 per minute will be charged for each child who remains at the center past 4:00, unless prior arrangements have been made with the Director or staff member responsible for closing the center.** If a child has not been picked up or parent has not contacted the school by 4:30 pm, **CHILD PROTECTIVE SERVICES WILL BE NOTIFIED.**

ATTENDANCE **Morning Only: _____(7:30-12:20)**
Full Day _____(7:30-4:00)

Circle requested days: Monday Tuesday Wednesday Thursday

The purpose of this agreement is to provide protection for the parents as well as the Teddy Bear Preschool. In order to ensure that we provide the service contracted for, it is essential that the financial status of the center be stable. Therefore, this agreement provides a guarantee that you will financially support the enrollment space guaranteed for your child. We follow the current school calendar and you will only be charged for days that we are in school i.e no charge for holidays, weekends, snow days, etc. A school calendar is included in this packet.

Parent/Guardian Signature

Date

Director Signature

Date

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“TOWARDS A BETTER UNDERSTANDING OF YOUR CHILD”

Child's Name _____ Date of Birth _____

Please help me get to know your child: As your child's teacher, I would like this year to be the first of many positive school experiences. The more I know about the children in my class, the better I can meet their needs. It would help greatly if you could answer the following questions:

*Has anyone else cared for your child or has your child gone to daycare/preschool before? Were these experiences positive or negative?

*What frustrates your child? How does your child handle a new task or stressful situation?

*How do you comfort your child? Does your child have a special blanket or toy?

*What methods of discipline do you use?

*How are your child's sleeping and eating habits?

*To better help your child's entry into our school setting, describe any recent family events or changes (such as death, divorce, new sibling, a move). Please keep staff current on any future changes.

*Does your child have any fears?

*How do you describe your child's personality?

*Your child's speech/language: How does your child communicate with you? Do you have any concerns?

*Is your child potty-trained? If so, does he/she require help with clothing, wiping, etc?

*Can you describe your child's attention span? Is he/she easily distracted?

*Your child's emotional development: How does your child respond to emotions he/she is feeling?

*How is your child's physical development: Is he/she able to move appropriately for his/her age?

*Does your child react to noise or certain textures of food or clothing?

*Is there anything else you would like to tell us about your child? (favorite activities, people, places, toys)

*Can you tell us what traditions/celebrations your family observes or participates in?

*What goals do you have for your child this year?

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Sun Protection

1. The center must obtain the parent/guardian's written authorization and instructions for applying sunscreen to their children's exposed skin prior to outside play. A doctor's permission is not needed to use sunscreen at the center.
2. When applied for an individual child, the sunscreen must be labeled with the child's first and last name.
3. If sunscreen is provided by the center, parents must be notified in advance and in writing, of the type of sunscreen the center will use.
4. Children over 3 years of age may apply sunscreen to themselves under the direct supervision of a staff member.

.....

If you DO want your child to have sunscreen applied please sign and date below.

I give permission for _____ (Name of Child) to have sunscreen applied while at Teddy Bear Preschool. I understand that I will be given prior notice of the brand of sunscreen to be used.

Parent/Guardian Signature

Date

If you DO NOT want your child to have sunscreen applied, complete, sign and date below.

I DO NOT want my child _____, (Name of Child) to have sunscreen applied while at Teddy Bear Preschool.

Parent/Guardian Signature

Date

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FIELD TRIP PERMISSION FORM

We believe that educational field trips are beneficial and important to the overall development of the child. All trips will be well planned, organized and supervised. Notices will be sent home one week in advance before attending any field trip.

Please sign the consent below giving us permission to take your child on these excursions.

I give my consent for _____(Name of Child) to participate in walking field trips planned by Teddy Bear Preschool. I understand that I will be notified one week in advance of all outings.

Parent/Guardian Signature Date

SCREENING PERMISSION FORM

Child's Name _____

I give permission for staff to implement developmental screenings with my child.
(circle one)

Yes No

.....

HEARING & VISION SCREENINGS

I give permission for my child to participate in hearing and vision screenings.

Yes No

Teddy Bear Preschool
1550 Hillside Avenue
Dolores, CO 81323

August 14, 2024

Families,

The state licensing and the health department require us and the children to wash their hands multiple times a day; resulting in dry, cracked hands. We can provide lotion (Lubriderm) or if you prefer, you may bring something else for us to use. We need parental permission to apply lotion so please indicate below your preference.

Thank you,

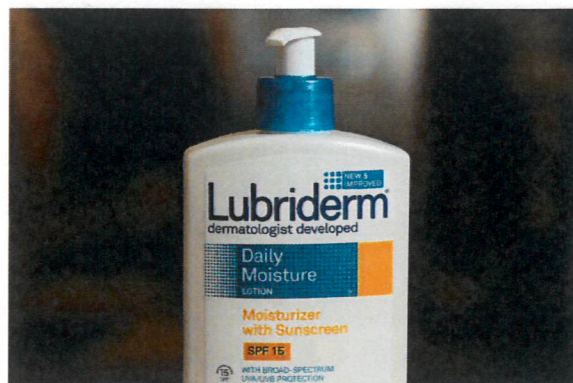
I _____, (Print Parent/Guardian Name), give permission for the
Teddy Bear Staff to apply Lubriderm lotion to my child's hands/face.

OR

I, _____,(Print Parent/Guardian Name) give Teddy Bear Staff
permission to apply the lotion that I have provided, _____(Print
Name of Lotion provided)

Parent Signature

Date



TEDDY BEAR PRESCHOOL

FOR SCHOOL USE ONLY

TODDLER _____ PRESCHOOL _____

First Name _____ Middle Name _____ Last Name _____

Date of Birth _____ Sex _____ Age _____

Physical Address _____ City _____ Zip _____

Mailing Address _____ City _____ Zip _____

(Please circle the appropriate choice) _____ MOTHER _____ STEP-MOTHER _____ GUARDIAN

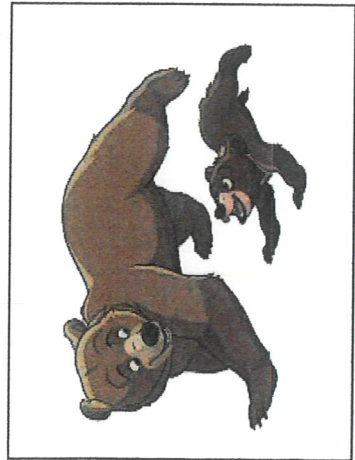
Name _____ Phone _____

EMAIL* Required _____

(Please circle the appropriate choice) _____ FATHER _____ STEP-FATHER _____ GUARDIAN

Name _____ Phone _____

EMAIL* Required _____



Are you experiencing homelessness or living with others while in transition? Yes _____ No _____

PHOTO/VIDEO PERMISSION: Please circle either Yes or No whether your child may be photographed or videotaped as part of a school event or program.

ETHNICITY Is this student Hispanic/Latino Yes _____ No _____

Mark the one or more that describes the student's race.

- _____ White _____ Asian _____ American Indian or Alaska Native
- _____ Black /African American _____ Native Hawaiian / Pacific Islander

GENERAL HEALTH APPRAISAL FORM

PARENT

Please complete, date, and SIGN.

Child's Name: _____ Birthdate: _____

Allergies: None OR List food/medication: _____

Diet: Breastfed Age appropriate Special-Describe: _____

Skin Care: Sunscreen/creams may be applied as requested in writing by parent unless skin is broken or bleeding.

Sleep: Your healthcare provider recommends that all infants less than 1 year of age be placed on their back for sleep.

I, _____, give permission for my child's healthcare provider to share this form and applicable attachments with my child's school, childcare, or camp. Contact information for the person to receive this form:

Name: _____ Fax: _____ Email: _____

Parent/Guardian Signature: _____ Date: _____

HEALTH CARE PROVIDER

Please complete after parent section has been completed.

Date of most recent health appraisal: _____ Age: _____ Weight: _____

Physical Exam: Normal Abnormal-describe: _____

Allergies: None OR List food/medication: _____ Type of Reaction _____

Current Medications: None OR List: _____

A separate medication authorization form ([link](#)) is required for medications given in school, childcare, or camp.

Current Diet: Breastfed Age appropriate Special-describe: _____

A separate diet statement ([link](#)) is required for food provided at school, childcare, or camp.

Health Concerns: Severe Allergies Asthma Seizures Diabetes Hospitalizations Behavior Concerns
 Developmental Delays Vision Hearing Oral Health Under/Overweight Other: _____

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

Immunizations: See attached immunization record or official exemption form Next vaccine due date: _____

HEALTH CARE PROVIDER

Please complete if appropriate. This information is required by Early Head Start and Head Start Programs per the State EPSDT Schedule.

Height: _____ B/P: _____ Head Circumference (up to 12 months): _____ HCT/HGB: _____

Lead Level: Not at risk OR Lead level: _____ TB: Not at risk OR Test Result: Normal Abnormal

Screens Performed: Vision: Normal Abnormal Hearing: Normal Abnormal

Oral Health: Normal Abnormal Developmental Screen: ASQ PEDS Other: _____

Developmental Concerns: _____ 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, childcare, or camp. Any concerns or exceptions are identified on this form.

Signature of Healthcare Provider (certifying form reviewed)

Date

*The AAP recommends Well Child Visits at 2, 4, 6, 9, 12, 15, 18, 24, and 30 months, and annually after 3 years.

OFFICE STAMP

Or write Name, Address, Phone Number, Email