COURT CARE FOR THE PIKES PEAK REGION, INC.
Operated By Early Connections Learning Center

Registration Form
Colorado Springs CO 80903
719-452-5499

Today's Date:______________________________________

Name of Parent/Guardian:____

Street Address:_________________________________ Apartment#_____________________________

City/Town :____ Zip Code_________________________

Telephone Number:________________________________ Cell Phone Number:__________________/

Military: YES NO ACTIVE NON-ACTIVE OVER SEA

Branch: Army___ Air Force____ Navy ___ Marines ___ Coast Guard ____ Reserves___ Case# _______

Household Size: 1 person____ 2 Person____ 3 Person_____ 4 Person_____ 5 Person_____ 6 Person____ 7+ ____

Head of Household: Male _____ Female _____

Annual Household Income: $_______________ **This *information is kept confidential and is only used for grant reporting purposes***

Are you: Disabled __Yes __No Homeless __Yes __No Migrant Farm Worker __ Yes __No

Do you receive: SSI __Yes __No CCAP __ Yes __No WIC __Yes __No TANF __Yes __No

Does your child/ren have health insurance_______ Yes ________ No

Would you like more information on Health Insurance? Yes _______ _______No

Parent/Guardian Signature: ____

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1) Child's Name:_______________________________________ DOB:______________________

Allergies: Yes_____ No_____ To What?_________________ Allergic Reaction_________________________

Special Needs: Does your child have any special physical or developmental needs? (autism, vision or hearing impairment,

ADD, ADHD, other) ____

Formula_____ How many ounces_______ Breast Feed ____ Medical/Physical Restrictions_________________________

Sex: Male_____ Female_____ Ethnicity: Hispanic _______ Non- Hispanic ________

Race: White_____ Black/African American_____ Asian_____ American Indian/Alaskan Native ______
Native Hawaiian/Other Pacific Islander_______ Other Multi-Racial _______

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2) Child's Name_________________________________ DOB_____________________________________

Allergies: Yes_____ No_____ To What?_________________ Allergic Reaction_________________________

Special Needs: Does your child have any special physical or developmental needs? (autism, vision or hearing impairment,

ADD, ADHD, other) ____

Formula_____ How many ounces_______ Breast Feed ____ Medical/Physical Restrictions_________________________

Sex: Male_____ Female_____ Ethnicity: Hispanic _______ Non- Hispanic ________

Race: White_____ Black/African American_____ Asian_____ American Indian/Alaskan Native ______
Native Hawaiian/Other Pacific Islander_______ Other Multi-Racial _______

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3) Child's Name_________________________________ DOB_____________________________________

Allergies: Yes_____ No_____ To What?_________________ Allergic Reaction_________________________

Special Needs: Does your child have any special physical or developmental needs? (autism, vision or hearing impairment,

ADD, ADHD, other) ____

Formula_____ How many ounces_______ Breast Feed ____ Medical/Physical Restrictions_________________________

Sex: Male_____ Female_____ Ethnicity: Hispanic _______ Non- Hispanic ________

Race: White_____ Black/African American_____ Asian_____ American Indian/Alaskan Native ______
Native Hawaiian/Other Pacific Islander_______ Other Multi-Racial _______

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4) Child's Name_________________________________ DOB_____________________________________

Allergies: Yes_____ No_____ To What?_________________ Allergic Reaction_________________________

Special Needs: Does your child have any special physical or developmental needs? (autism, vision or hearing impairment,

ADD, ADHD, other) ____

Formula or Breast Feed How many ounces_______ Medical/Physical Restrictions_________________________

Sex: Male_____ Female_____ Ethnicity: Hispanic _______ Non- Hispanic ________

Race: White_____ Black/African American_____ Asian_____ American Indian/Alaskan Native ______
Native Hawaiian/Other Pacific Islander_______ Other Multi-Racial _______

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5) Child's Name_________________________________ DOB_____________________________________

Allergies: Yes_____ No_____ To What?_________________ Allergic Reaction_________________________

Special Needs: Does your child have any special physical or developmental needs? (autism, vision or hearing impairment,

ADD, ADHD, other) ____

Formula or Breast Feed How many ounces_______ Medical/Physical Restrictions_________________________

Sex: Male_____ Female_____ Ethnicity: Hispanic _______ Non- Hispanic ________

Race: White_____ Black/African American_____ Asian_____ American Indian/Alaskan Native ______

Native Hawaiian/Other Pacific Islander_______ Other Multi-Racial _______
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COURT CARE FOR THE PIKES PEAK REGION, INC.
Operated By Early Connections Learning Center
Authorization And Consent Form

I, the undersigned, hereby instruct the Early Connections Learning Center or any of its agents to take whatever steps may be necessary to obtain or administer emergency medical care to the benefit of my child(ren) while in attendance at Early Connections Learning Centers, and in my absence. These steps may include, but are not limited to the following:

1. Attempt to contact me
2. Call paramedics

I release Early Connections Learning Center and its agents from any liability for decisions made in good faith in obtaining or administering such emergency treatments.

I understand that I am responsible for providing all information to the care of my child(ren) at the time of enrollment and Early Connections Learning Center will not be responsible for anything that might happen as a result of missing or false information given at the time of enrollment.

To protect my child(ren), rigorous health standards are maintained. Hand washing and a "health check" will be required upon entry. Because of these health standards, I understand that Child Nursery Centers is not able to provide care for children who are at any contagious stage of an illness.

I understand that it is my responsibility to sign in my child(ren) upon arrival and out upon departure. No other person may be authorized to pick up my child(ren) unless an unforeseen incident occurs in Court.

I understand every attempt will be made to contact me in the event of an emergency requiring medical attention for my child(ren)____However, if I cannot be reached, I hereby authorize Early Connections Learning Center to transport my child to the nearest medical facility, and to secure for my child the necessary medical treatment. I understand the staff members in the child care center are trained in the basics of First Aid and CPR. I authorize them to give my child first aid and/or CPR when appropriate.

I have read Early Connections Learning Center policies and procedures and am in agreement with them.

____ ___________________________
Parent/Guardian Signature Date

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In case of emergency, where parent/guardian cannot be reached, the following persons are authorized to pick up my child(ren):

1. Name___________________________ Relationship To Child ___________________/

   Telephone No.____________________/

2. Name _________________________ Relationship To Child __________________/

   Telephone No.___________________

3. Name______________________ Relationship To Child____________________________

   Telephone No.___________________________

____ ___________________________
Parent/Guardian Signature Date

COURT CARE FOR THE PIKES PEAK REGION, INC.
Operated By Early Connections Learning Center
PROGRAM POLICIES

1. The Early Connections Learning Center at South Tejon has space available for children from 6 week through 14 years of age.

2. The Center is open from 7:30 a.m. to 5:00 p.m. Monday through Friday. The center is closed from 12:00 p.m. to 12:30 p.m. for lunch. Children will need to be picked up during this time unless otherwise authorized. Parents may bring their children 15 minutes prior to the court appointment and return immediately following their court business

3. For your child's safety and protection, the person who signed the child in to the Center must also sign the child out of the Center.

4. If for any reasons you need to leave the court premises for other than court business, you must take your child with you.

5. If your child is not picked up by 5:30 p.m. and/or no contact has been made, it is understood that the Emergency Contact Person will be contacted and will be authorized to pick up your child. If the Emergency Contacts cannot be reached, The Department of Human Services and the Police Department will be contacted after 5:30 p.m. to pick up your child(ren).

6. Any child who has a contagious disease will not be allowed in the Center. This includes head lice.

7. The Center will obtain medical care for your child in case of emergency.

8. In accordance with state law, Early Connections Learning Center must report any suspected child abuse or neglect.

9. Only those individuals having court business are authorized to use Court Care For The Pikes Peak Region, Inc. It is understood that the information given may be verified with the court.

10. Early Connections Learning Center is not responsible for any lost or stolen items left at the Center. The Center will do its best to keep all of your child's items together during their visit. Please take all valuables with you. It would be helpful to have your child's items labeled.

11. It is understood that you must return as soon as your court business is finished. Please make sure to have a court representative sign your form when leaving your courtroom.

I have read and understand these policies

____________________________________ _________________________
Signature of Parent/Guardian Date

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Early Connections Learning Center Employee

COURT CARE FOR THE PIKES PEAK REGION, INC.
Validation Of Child Care Use
719-452-5499

PLEASE GIVE THIS CARD TO THE CLERK UPON ENTERING THE COURTROOM

PLEASE MAKE SURE CARD IS SIGNED WHEN COURT BUSINESS IS FINISHED AND RETURN CARD TO THE CENTER

Parent/Guardian Name:______________________________ Date: ___________________/

Check One: Petitioner____ Witness____ Defendant____ Juror____ Victim __Other____

# of Children:___________ Ages:____________ Appt Time:____________ AM/PM

Time Out: ____________ AM/PM

Division: __________________

________________________________ ________________________________

Print Court Official Name **Contact Phone Number**

Other Departments:

	Clerk	Clinic	Comm. Serv.	D.A.	Prob.	Other
Initials:	_____	_____	_____	_____	_____	____
Time Out:	_____	_____	_____	_____	_____	_____

REFERRAL FOR CHILD CARE SERVICES

________________________________ ________________________________
AUTHORIZED REFERRAL SIGNATURE **REFERRING AGENCY&PHONE NUMBER**

________________________________ ________________________________
PRINT NAME **TITLE**

****** If in the event that we needed to evacuate please meet us at the Pioneer Museum by the steps on the Tejon side.******