

Mild Allergy & Food Sensitivity Information

Name: _____ Birth Date: _____

Center/School _____ Classroom/ Teacher _____

Please list all allergies (Food, Medication, Insects, etc.)	Reactions (Symptoms, Date)
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____

List any MEDICATIONS used for this allergy. *If "emergency" medications are used (i.e. Epinephrine- EpiPen or others) the **SEVERE ALLERGY care plan** must be filled out*

1. _____
2. _____
3. _____

Please list in detail any DIET restrictions:

Any other information that would be helpful:

Emergency Contact Information

Parent/Guardian Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Parent/Guardian Signature: _____ Date: _____

Nurse Consultant Review: _____

Permission To Administer Medication in Child Care / School

(one form per medication)

➤ To be completed by the child's health care provider with prescriptive authority:

CHILD _____ Birthdate _____

Medication _____

Dose _____ Route _____

Time of day medication is to be given _____

Special Instructions _____

Reason for medication _____

Possible Side Effects _____

START DATE _____ END DATE _____

Signature of Person with Prescriptive Authority _____ License Number _____

Print Name _____

Phone _____ Date _____

➤ To be completed by the parent or guardian

I hereby give my permission for _____
(Child's name)

to take the above medication in this center, as ordered by the health care provider.

I understand it is my responsibility to furnish this medication. I give permission for this information to be used in my child's facility, and for the person administering the medicine or nurse consultant to contact the above named physician by phone, fax, or in writing when necessary.

Parent / Guardian Name _____ Signature _____

Home Phone _____ Work phone _____

- The medication is to be brought in the original container which clearly states the child's name, the name of the medication, date, time, and dosage. If a prescription, it *also* needs to have the pharmacy name and phone number, licensed health care provider's name, and date medicine is to be stopped.
- This form must be filled out completely in order for the medication to be given. This is a Division of Early Care & Learning Licensing requirement (R&R 7.702.62C).

School year 20____ - 20____ C.R.S. 22-1-119.5 A treatment plan shall be effective only for the school year in which it is approved.

Student's name: _____ D.O.B.: _____ Grade: _____ School: _____ Teacher/Classroom: _____ Allergy to: _____ History: _____	Place student's photo here
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Emergency-use epinephrine: ☐ 0.1 mg auto-injector ☐ 0.15 mg auto-injector ☐ 0.3 mg auto-injector
☐ 1 mg nasal spray ☐ 2 mg nasal spray

Antihistamine (if prescribed) medication, dose, route, frequency: _____

Self-administer? ☐ No ☐ Yes - If yes, student has been instructed and is capable of carrying and self-administering own emergency-use epinephrine medication. Note: A trained staff member must be available to administer in the event the student is unable to self-administer for any reason.

If you see this:	Do this:
Green zone: normal activities - no symptoms	
Student may participate in all normal activities.	- Continue to avoid known allergens. - Ensure emergency medications are readily available.
Yellow zone: mild symptoms	
Affecting one body system only: Nose: Itchy, runny nose, sneezing Skin: A few hives, mild itch Gut: Mild nausea/discomfort	- Stay with student. - Give antihistamine (if prescribed above). - Alert parent/guardian and school nurse.  If symptoms spread to a second body system, immediately move to red zone. - Continue to monitor closely.
Red zone: severe symptoms	
Two or more body systems with mild symptoms or any severe symptoms in one or more body systems: Lung: Short of breath, wheezing, repetitive cough Throat: Tight, hoarse, trouble breathing/swallowing Mouth: Swelling of the tongue and/or lips Heart: Pale, blue, faint, weak pulse, dizzy Skin: Many hives over body, widespread Gut: Vomiting or diarrhea (if combined with other symptoms) Other: Feeling something bad is about to happen, confusion, agitation	Give epinephrine immediately! Call 911! - Tell 911 dispatch that epinephrine was given. - Tell EMS what time epinephrine was given. - Stay with student and: - Monitor student, keeping them lying on their back; if vomiting or difficulty breathing, put student on their side. - Call parent/guardian and school nurse. - Give 2nd dose if symptoms worsen or do not improve, or if symptoms return, as ordered above (if available). - Give other prescribed medications after administering epinephrine (if available).  Important: Do not hesitate to administer epinephrine. Key principle: If allergic reaction affects two body systems, give epinephrine as a first-line treatment.

Healthcare provider name (print): _____ Phone number: _____

Provider signature: _____ Date: _____

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices and release the school and personnel from any liability in compliance with their Board of Education policies.

Parent/guardian name (print): _____ Phone number: _____

Parent's/guardian signature: _____ Date: _____

School nurse signature: _____ Date: _____

For the school nurse: Self-carry contract on file? ☐ No ☐ Yes Meal modification form? ☐ No ☐ Yes



Official Colorado Certificate of Immunization

<https://cdphe.colorado.gov/immunization-requirements-school-entry>



COLORADO
Department of Public
Health & Environment

This official certificate of immunization shall be: 1. Completed by a health care provider (licensed physician [MD, DO], advanced practice nurse [APN], physician assistant [PA]), public health official, or school health authority, or 2. Generated electronically from the Colorado Immunization Information System (CIIS). According to [6 CCR 1009-2](#), if the student provides an immunization record in any other format apart from this official certificate of immunization or a CDPHE approved alternate certificate of immunization, the school health authority must transfer the immunization record onto this form, and a signature is required. School-required immunization requirements are on Colorado's [immunization requirements for school entry](#) webpage.

Student name: _____ Date of birth: _____

Parent or guardian name (only if student is under 18 years of age and not emancipated): _____

Required immunizations	Immunization date(s) MM/DD/YYYY						Titer date* MM/DD/YYYY
HepB (hepatitis B)							
DTaP (diphtheria, tetanus, pertussis)							
Tdap (tetanus, diphtheria, pertussis)							
Td (tetanus, diphtheria) †							
Hib (<i>Haemophilus influenzae</i> 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			*The shaded area under "titer date" indicates that a titer is not acceptable proof of immunity for this vaccine.				

In several instances, laboratory confirmation of positive titers are an acceptable alternative to written documentation of vaccination. A positive laboratory titer report must be provided to the school to document immunity. More information on titers can be found within the Colorado Board of Health rule [6 CCR 1009-2](#).

† For DTaP and Tdap, both the diphtheria and tetanus titers must be positive. A titer is never acceptable to demonstrate immunity to pertussis.

‡ Laboratory confirmation of positive titers are an acceptable alternative to the MMR vaccine only when titers for all three components (measles, mumps, and rubella) are positive.

Recommended immunizations

	Immunization date(s) MM/DD/YYYY					
RSV (respiratory syncytial virus)						
HPV (human papillomavirus)						
RV (rotavirus)						
MCV4 (meningococcal ACWY)						
MenB (meningococcal B)						
HepA (hepatitis A)						
Flu (influenza)						
COVID-19						
Other						

Official certificates of immunization generated by CIIS or a school or practitioner's Electronic Health Record do not require a signature. However, if a health care provider, public health official, or school health authority adds information to this form, electronically or by hand, they must sign it below.

Printed name: _____ Date: ____/____/____

Signature: _____ Title: _____

(Optional): For school use only: Schools may use this form or their own system to document verification that the student is in compliance with the immunization requirements to attend school.

This student is in compliance until ____/____/____ (specific date) or ____-____ (school year) or ____ (grade)

____ (staff name) ____ (staff title)

(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 or guardian or emancipated student (including those over 18 years old) Signature: _____ Date: _____

Under Colorado law, you have the option to exclude your child's or your information from CIIS at any time.

To opt out of CIIS, go to www.colorado.gov/cdphe/ciis-opt-out-procedures.

Last revised: July 2025

MEDICATION WAIVER

If any medication (over-the-counter or prescription) needs to be administered at school, a parent/guardian is responsible for providing the medication and the required forms.

This form states that I (Parent/Guardian) am choosing to NOT provide or keep possible forms and/or medication at school for my child or have them self carry (middle school age and up).

I, _____ (Parent/Guardian *PRINTED* name)

The Parent/Guardian of:

Print Child's Name: _____

School: _____

Grade: _____

Medical Condition: _____

am choosing to NOT keep Medication(s) and/or permission forms at school or have my child self carry as per school policy.

List medications not being provided or self-carry:

I have been able to ask questions and am aware of the school's medication policy and understand this WAIVER. I understand the possible severity of my child's condition and that it may be life-threatening. 911 will be contacted in an emergency. I assume financial responsibility of any costs incurred.

The undersigned parent(s) or guardian(s) hereby agree to release the school and its personnel from any and all claim(s), which they now have or may hereafter have arising regarding the consequences of this waiver action plan.

Parent/Guardian Signature

Date

Phone

This waiver is effective indefinitely unless changed by Parent/Guardian

Name _____ Date of Birth _____

Parent/Guardian _____

**STATEMENT OF EXEMPTION TO IMMUNIZATION LAW
(DECLARACIÓN RESPECTO A LAS EXENCIONES DE LA LEY DE VACUNACIÓN)**

IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS MAY BE SUBJECT TO EXCLUSION FROM SCHOOL AND TO QUARANTINE.

SI SE PRESENTA UN BROTE DE LA ENFERMEDAD, ES POSIBLE QUE A LAS PERSONAS EXENTAS SE LES PONGA EN CUARENTENA O SE LES EXCLUYA DE LA ESCUELA.

MEDICAL EXEMPTION: The physical condition of the above named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.

EXENCIÓN POR RAZONES MÉDICAS: El estado de salud de la persona arriba citada es tal que la vacunación significa un riesgo para su salud o incluso su vida; o bien, las vacunas están contraindicadas debido a otros problemas de salud.

Medical exemption to the following vaccine(s):

La exención por razones médicas aplica a la(s) siguiente(s) vacuna(s):

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☒ VAR

Signed (Firma) _____ Date (Fecha) _____

Physician (Médico)

RELIGIOUS EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a religious belief opposed to immunizations.

EXENCIÓN POR MOTIVOS RELIGIOSOS: El padre o tutor de la persona arriba citada, o la persona misma, pertenece a una religión que se opone a la inmunización.

Religious exemption to the following vaccine(s):

Exención por motivos religiosos de la(s) siguiente(s) vacuna(s):

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☒ VAR

Signed (Firma) _____ Date (Fecha) _____

Parent, guardian, emancipated student/consenting minor
(Padre, tutor, estudiante emancipado o consentimiento del menor)

PERSONAL EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a personal belief opposed to immunizations.

EXENCIÓN POR CREENCIAS PERSONALES: Las creencias personales del padre o tutor de la persona arriba citada, o la persona misma, se oponen a la inmunización.

Personal exemption to the following vaccine(s):

Exención por creencias personales de la(s) siguiente(s) vacuna(s):

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☒ VAR

Signed (Firma) _____ Date (Fecha) _____

Parent, guardian, emancipated student/consenting minor
(Padre, tutor, estudiante emancipado o consentimiento del menor)



Immunization

Certificate of Nonmedical Exemption

cdphe.colorado.gov/immunization

Colorado law C.R.S. § 25-4-902 requires all students attending any school in the state of Colorado to be vaccinated against certain vaccine-preventable diseases, as established by Colorado Board of Health Rule 6 CCR 1009-2, unless an exemption is filed. This law applies to students attending public, private and parochial kindergarten, elementary and secondary schools through 12th grade, colleges or universities, and child care facilities licensed by the Colorado Department of Human Services including child care centers, school-age child care centers, preschools, day camps, resident camps, day treatment centers, family child care homes, foster care homes, and Head Start programs. "Nonmedical exemption" means an immunization exemption based upon a religious belief whose teachings are opposed to immunizations or a personal belief that is opposed to immunizations. Prior to kindergarten, the Certificate of Nonmedical Exemption must be filed each time a student is due for vaccines according to the schedule developed by the Advisory Committee on Immunization Practices (ACIP).^{1,2} From kindergarten through 12th grade, the Certificate of Nonmedical Exemption must be filed every year during the student's school enrollment/registration process.¹ Students with an immunization exemption on file may be kept out of a child care facility or school during a disease outbreak. The length of time will vary depending on the type of the disease and the circumstances of the outbreak.

Complete all required fields as indicated by an asterisk* below and obtain all required signatures. Incomplete forms will not be accepted. Completing all fields allows for us to process this exemption in a more expedited manner and to contact you should questions arise.

Student Information:

*Last Name:	*First Name:	Middle Name:
*Date of Birth:	Email:	*Sex: ☐ Female ☐ Male ☐ X

Parent/Guardian Completing This Form: ☐ Check if an emancipated student or student over 18 years old

If emancipated and under 18 years of age, please submit this exemption form and your emancipation documentation to cdphe.ciis@state.co.us

*Last Name:	*First Name:	Middle Name:
Relationship to student: ☐ Mother ☐ Father ☐ Legal Guardian		

School/Licensed Child Care Facility Information:

*School Name/Licensed Child Care Facility:		
School District:	☐ Check if Not Applicable	
*Address:		
*City:	*State:	*Zip Code:

*Required Vaccines for School Entry - Place an "X" next to each vaccine for which you are claiming a nonmedical exemption.

	Diphtheria, tetanus, pertussis (DTaP)	Inactivated poliovirus (IPV)
	Tetanus, diphtheria, pertussis (Tdap)	Measles, mumps, rubella (MMR)
	Haemophilus influenzae type b (Hib)	Pneumococcal conjugate (PCV)
	Hepatitis B (HepB)	Varicella (chickenpox)

Statement of Exemption

I am the parent/guardian of the above-named student or am the student himself (emancipated or over 18 years of age) and am claiming a nonmedical exemption from the vaccine(s) indicated above. The information I have provided on this form is complete and accurate. I can review evidence-based vaccine information at www.colorado.gov/cdphe/immunization-education, <https://childvaccineco.org/>, and, www.immunizeforGood.com/ for additional information on the benefits and risks of vaccines and the diseases they prevent. I can contact the Colorado Immunization Information System (CIIS) at www.covaxrecords.org or my health care provider to locate my child's/my immunization record.³

*REQUIRED: Signature: _____ Date: _____
Parent/Legal Guardian/Student (emancipated or over 18 years old)

REQUIRED Provider Signature Section:

*REQUIRED: Print Name, Title, and Signature: _____ Date: _____
Physician (MD, DO), Advanced Practice Nurse (APN), Physician Assistant, Registered Nurse (RN) or Pharmacist (authorized pursuant to section 12-240-107 (6), C.R.S.)

*REQUIRED: Colorado professional license number: _____
☐ Check if completed during the school's designated early registration period for the upcoming school year.

DO NOT use this process or form for work-related vaccine exemptions or for vaccines that are not required for school entry in the state of Colorado. This includes vaccines for: COVID-19, hepatitis A (HepA), human papillomavirus (HPV), influenza (flu), meningococcal disease (MenACWY and MenB), and rotavirus (RV).

¹ Colorado Board of Health Rule 6 CCR 1009-2: <https://cdphe.colorado.gov/schoolrequiredvaccine>

² Recommended Immunizations from Birth through 6 Years Old: www.cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf. Based on this schedule, a Certificate of Exemption would be submitted at 2 months, 4 months, 6 months, 12 months, and 18 months of age.

³ Under Colorado law, you have the option to exclude your child's/your information from CIIS at any time. To opt out of CIIS, go to www.colorado.gov/cdphe/ciis-opt-out-procedures.

*Please be advised you will be responsible for maintaining your child's/your immunization records to ensure school compliance.