*** You will need to: 1) save a blank form to your computer, print it and fill it out, return completed form to ECC or 2) Click Enable All Features, fill form out and print, return to ECC. You will not be able to save a completed document to your computer.
** Indicates required information

Start Date:

CHILD INFORMATION

First & Last Name

◯ Male
◯ Female

Home Phone #

Nickname to be used on symbol

Date of Birth

Racial Ethnicity:

☐ Caucasian ☐ Hispanic ☐ Black / African American ☐ Asian ☐ Other ______

☐ American Indian / Alaskan Native ☐ Native Hawaiian / Other Pacific Islander

Doctors Name **

Dentist Name **

Doctors Address **

Dentist Address **

Doctors Phone **

Dentist Phone **

Child's Allergies or Medical Concerns

Names and ages of brothers & sisters

Specific Eating Requirements

Specific Bathroom Needs

Fears

Other information about your child that may be helpful for staff to know

Emergency Consent:

In the event that my child ______________________ may require emergency medical care. I hereby give my consent for medical treatment to the Sioux Center Health to provide this care. Also, I understand that my child may need to be transported by ambulance to the SCH when staff determine an emergency situation. In the event that my child (listed above) may require dental and or dental surgical care while I am out of town or unable to be reached, I hereby give my consent to Dr. Addink, Uribe, VanEs, or Bylsma-Mulder (choose one below, must be a Sioux Center dentist) or his designee to provide this care. I agree to pay the entire costs and fees contingent. I understand that this consent is effective for as long as my child is enrolled in the childcare facility or until I complete a new form.

☐ Dr Addink ☐ Dr Uribe ☐ Dr VanEs ☐ Bylsma-Mulder

Signature of Parent / Guardian:

Date:

Mother's Information

Mother's E-Mail

First & Last Name

Address

City

State

Zip Code

Home Phone

Work Phone

Cell Phone

Pager

Employer

Employer Address

Status of Parents

☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

Father's Information

Father's E-Mail

First & Last Name

Address

City

State

Zip Code

Home Phone

Work Phone

Cell Phone

Pager

Employer

Employer Address

Travel & Activity Authorization

I do / do not give permission for my child ______________________________ to leave the Early Childhood Center for trips in a car driven by staff or other volunteers to special places. I understand that I will be notified before any such activity and that my child will be secured in a safety seat (through 5 years of age) and in a seat belt (children 6 years old and older).

☐ Do ☐ Do Not

Signature of Parent / Guardian:

Date

Picture Release

I do / do not give permission to let my child be photographed for use by the center for bulletin boards, local newspapers, or other media for the purpose of education al activities, publicity, or advertisements.

☐ Do ☐ Do Not

Signature of Parent / Guardian: ______________________________

Date

Authorization for Release of Information

I do / do not give my consent for my child's first name and / or parent's first name to be given to other families enrolled at the *Early Childhood Center* for things such as party invitations, Active Learning preschool lists and room lists.

☐ Do ☐ Do Not

Parent / Guardian Signature

Date

Insurance Coverage Information

The company insuring your child is

The ID# is

Parent / Guardian Signature Date

Consent for Non-Prescription Medication

Please check the following items that you give permission to be given or applied to your child

☐ Soap ☐ Baby Wipes (Ingredients of baby oil & baby lotion)

☐ Baby Lotion ☐ Fever Reducing Medication (such as Tylenol) Other ____________________

Signature of Parent / Guardian: Date

Consent for Sunscreen

☐ I give my permission for personnel at the *Early Childhood Center* to apply a sunscreen product of SPF-15 or higher to my child when he or she will be playing outside, especially during the months of June through August and between the daily times of 10 a.m. and 4 p.m. I understand that sunscreen may be applied to exposed skin, including but not limited to the face, tops of the ears, nose and bare shoulders, arms, and legs.

☐ My child is allergic to some sunscreens. I will provide an appropriate sunscreen as well as a Doctor's note.

Signature of Parent / Guardian: Date

Emergency Contact - Authorized to Pick-Up Child

(Other than Parents)

Contact Name | Relationship to Child

Phone # (include area code) | Phone # (include area code)

Contact Name | Relationship to Child

Phone # (include area code) | Phone # (include area code)

Contact Name | Relationship to Child

Phone # (include area code) | Phone # (include area code)

Others Who Have Authorization to Pick Up Child:

Name | Phone # | Relationship to Child

Name | Phone # | Relationship to Child

I have read the Early Childhood Center brochures and will make every effort to abide by their policies. Copies of all policies are located on the wall near the check in computers. Communication is so important: therefore, I will be responsible for checking my family mailbox regularly.

Signature of Parent / Guardian: Date

Iowa Child and Adult Care Food Program

Child Care Enrollment Form

Name ______________________ Date of Birth ____________

Indicate a choice from both Ethnic Identity and Race Identity sections below. Answering these questions is voluntary.
1. Ethnic Identity: My child is Hispanic? Mark Yes or No below. **2. Race Identity**: Mark in the appropriate box(s) below of the enrolled child.

1. Ethnic Identity of Child (choose one) ☐ Yes Hispanic or Latino ☐ No, not Hispanic or Latino

2. Race Identity or Child (choose one or more)

☐ American Indian or Alaska Native ☐ Asian ☐ White ☐ Black or African American

☐ Native Hawaiian/Other Pacific Islander

My child's usual time for attendance will be:

Day				
Monday	Arrive at	________	Leave at	________
Tuesday	Arrive at	________	Leave at	________
Wednesday	Arrive at	________	Leave at	________
Thursday	Arrive at	________	Leave at	________
Friday	Arrive at	________	Leave at	________

My child's anticipated meal participation will be: (check all that apply):

☐ Breakfast

☐ AM Snack

☐ Lunch

☐ PM Snack

Complete this section for Infant only (0 - 12 months) ☐ I am not enrolling in infant (skip this section)

As a participant in the USDA Child Nutrition Program, our center offers means to all ages of children. An infant feeding is based on current nutrition guidelines. Infant foods are appropriate for the age and developmental readiness of each infant. Please select (x) your choice(s) from the following options that will fulfill your infant's food needs.

☐ I will provide breast milk for my infant.
Center formula may be used to supplement feeding if necessary? ☐ Yes ☐ No

☐ I will provide infant formula for my infant. Name of formula:

☐ I accept the center's formula for my infant. Center uses Parent's Choice Formula.

☐ I will provide a statement from a medical authority for non-reimbursable formula: Name of Formula:
Name of Formula:

☐ **By electronically signing the Early Childhood Center Enrollment Form, I agree that my electronic signature is the legally binding equivalent to my handwritten signature. I will not at any time in the future, repudiate the meaning of my electronic signature or claim that my electronic signature is not legally binding.**

Signature of Parent / Guardian: ______________________

Early Childhood Center

Iowa Child Care Infant, Toddler, Preschool Age-Child Health Exam Form

Childs Name:______________________________ Birth Date: ______________ Age Today: ___________

Health care provider completes this page*

Height or Length: ________________________________

Blood Pressure (start @ age 3 yr) ______________
Hgb or Hct (anytime 6 - 9 mo) _________________
Blood Lead Level (@ age 1 yr & age 2 yrs) _____________

Exam Results (n - normal limits) otherwise describe)
HEENT
Oral / Teeth
Heart
Lungs
Stomach / Abdomen
Genitalia
Extremities, Joints, Muscles, Spine
Skin, Lymph Nodes
Neurological

Sensory Screening
Vision: Right Eye ________ Left Eye _________
Hearing: Right Ear ________ Left Ear ________
Tympanometry (may attach results)
Developmental Screening**
Personal Social
Fine Motor-Adaptive
Language
Gross Motor
Autism screening results
Psychosocial / behavioral results:
Developmental Referral Made Today: Yes _____ No _____

(Please provide if available)
Date of Last **Dental** Exam: __________________
Dental Referral Made Today: Yes ____ No ____
Will complete on this date: _______________

Immunizations: may attach a copy of the Iowa Department of Public Health Immunization Certificate.
Dta/P/DTP/Td
Hepatitis B
HIB
Influenza
MMR
Pneumococcal
Polio
Varicella
Other
TB testing (only for high-risk child)

Referrals made today:
_______ Referred to hawk-i today 1-800-257-8563

Medications: health professional authorizes the child may receive the following medications while at child care or preschool:

Dosage

___Cough Medications:
____ Diaper Cream:
_____ Fever or Pain Reliever:
_____ Sunscreen:
______ Other:

Health **Care Provider Name, Address, and Telephone** (Please provide, may use stamp)

* Iowa Child Care Regulations require an admission physical exam report within the previous year. Annually thereafter, a statement of health condition signed by an approved health care provider. The American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (RE9939, March 2000) www.aap.org
** Developmental screening procedures were expanded to include autism, developmental surveillance, and psychosocial/ behavioral screening July 2009 by the Iowa EPSDT Medicad program. Toll-free 800-383-3826 01/11

Health Provider Assessment Statement:

☐ This child may participate in developmentally appropriate child care / preschool with **No** health-related restrictions

☐ This child may participate in developmentally appropriate child care / preschool with the following restrictions:

Provider's Type (circle) MD DO PA ARNP

Health Provider Signature ______________________________

Date of Exam ___________________