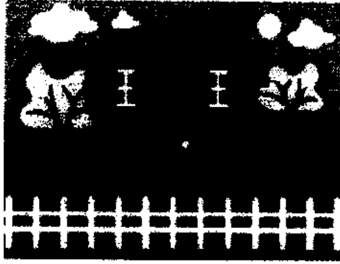


LITTLE HOME LEARNING CENTER

611 Eighth Street
P.O. Box 123
Lowden, IA 52255
Phone: 563.941.7790

Preschool Contract 2016-17

I have chosen the following options for preschool for the 2015 school year:

__________,Tuesday, Wednesday, Thursday 8:30-11:30 Preschool $125 a month

__________Tuesday, Wednesday, Thursday 8:00-8:30 Breakfast Program $25 a month

__________Wrap-Around Program 11:30-6:00 $15 per day

_____Tuesday

_____Wednesday

_____Thursday

I agree to pay $__________ monthly and $_________weekly for tuition and fees.

Child's Name ________________________________

Parent/Guardian Signature__________________________________ Date_____________

Little Home Learning Center
Fee Schedule Effective September 1, 2013

__Full Time Child Care:__

Infants (0-24 months) $140 per week
Two, Three, and Four Year Olds: $130 per week
School Age (Five Year Olds and Older) $120 per week

__Part Time Child Care:__

0-5 Year Olds: $35 per day
School Age: $25 per day

__Preschool:__

Three & Four Year Old Class (Monday-Wednesday 8:30-11:30) $125 per month
Preschool Breakfast Program (Monday-Wednesday 8:00-8:30) $25 per month
Preschool Wrap Around Program: $15 per day

__Before and After School:__

Before and After School: $55 per week/$13 per day
Before School Only: $25 per week/$6 per day
After School Only: $40 per week/$10 per day
No School Days: $25 per day (unless contracted weekly for before AND after school, then only additional $10 per day)
Early Out Days: Additional $5 to current rates (unless contracted weekly for before/after or after school, then no fee)
Summer Program: $120 per week or $25 per day

Family Discounts (only applies to full time):
Two Children: 10% off oldest
Three Children: 5% off oldest and 10% off 2nd oldest

Little Home Learning Center
Enrollment Form

Identifying Information:

Child's Name______________________________
Preferred name or nickname:______________________________
Date of Birth:______________ Male:______________ Female:______________
Hair Color:______________ Eye Color:______________
Identifying Marks:______________________________

Family Information:

Parent/Guardian:______________ Relationship to Child:______________
Home Address:______________________________
Home Phone:______________ Cell Phone:______________
Employer:______________________________
Work Address:______________________________
Work Phone:______________ Email:______________

Parent/Guardian:______________ Relationship to Child:______________
Home Address:______________________________
Home Phone:______________ Cell Phone:______________
Employer:______________________________
Work Address:______________________________
Work Phone:______________ Email:______________

Alternate Emergency Contacts:

Name:______________ Relationship to Child:______________
Home Phone:______________ Cell Phone:______________
Work Phone:______________ Other:______________

Name:______________ Relationship to Child:______________
Home Phone:______________ Cell Phone:______________
Work Phone:______________ Other:______________

The above persons are authorized to be called and can pick up my child in an emergency if I/We are not available or cannot be reached by the center.

Parent Signature:______________________________ Date:______________

Parent Signature:______________________________ Date:______________

LITTLE HOME LEARNING CENTER
Box 123
LOWDEN, IA 52255
563-941-7790

Emergency Medical Treatment Authorization/Consent Form
Please fill this form out completely or it will be returned to you to finish.

This form was completed on ______________________

Child's Full Name ______________________
Birth Date ______________________
Child's Age ______________________
Child's Sex ______________________

I, ______________________ parent or guardian of the child named above give my permission to ______________________, child care center, to secure and authorize such emergency medical care, emergency dental care and treatment as my child might require while under the Center's supervision. I also authorize the Center to administer emergency care or treatment as required, until emergency medical assistance arrives. I also agree to pay all the costs and fees contingent on any emergency medical care and treatment for my child as secured or authorized under this consent.

NOTE: Every effort will be made to notify parents immediately in case of emergency. In the event of an emergency, it would be necessary to have the following information:

Name of Parent or Legal Guardian: ______________________
Address: ______________________
Phone Numbers: Home: ______________________
Cell: ______________________ Work/School ______________________

Name of Parent or Legal Guardian: ______________________
Address: ______________________
Phone Numbers: Home: ______________________
Cell: ______________________ Work/School ______________________

Doctor: ______________________
Doctor's Address: ______________________
Doctor's Phone: ______________________
Preferred Hospital to Contact: ______________________

Dentist: ______________________
Dentist's Address: ______________________
Dentist's Phone: ______________________

Present medication(s): ______________________
Known allergies: ______________________
Insurance: ______________________

Physical on child completed on ______________________
Immunization records give to center on ______________________
If your child's religious affiliation is contrary to medical treatment or immunization requirements, you provided the center with a notarized statement on ______________________

The following individuals may be contacted in case of emergency and my child may be released to them:

Name:____________________
Address:____________________
Phone Numbers: Home:____________________
Cell:____________________ Work/School____________________
Relationship to child____________________

Name:____________________
Address:____________________
Phone Numbers: Home:____________________
Cell:____________________ Work/School____________________
Relationship to child____________________

Name:____________________
Address:____________________
Home Phone Numbers: Home:____________________
Cell:____________________ Work/School____________________
Relationship to child____________________

Name:____________________
Address:____________________
Phone Numbers: Home:____________________
Cell:____________________ Work/School____________________
Relationship to child____________________

Please circle your response and fill in the blank if applicable.

I do or do not give consent for my child to attend center-sponsored field trips. This may include walking, car, van, bus or public transportation.

I do or do not give consent for center staff to transport my child to and from school in a center-owned vehicle using only one staff.

I do or do not give consent for my child to attend non center activities. My child will attend the following non center activities:____________________

I do or do not give consent for sun block to be applied to my child's skin. If you have a preference on sun screen you must provide it with the child's name written on the container in a permanent marker. Please list the preferred sun screen if applicable____________________

I do or do not give consent for my child's picture to be taken.

I do or do not give consent for my child to be videotaped.

Parent/Legal Guardian's Signature____________________Date__________

Parent/Legal Guardian's Signature____________________Date__________

RELEASE AUTHORIZATIONS

Facility Name/Address ____

TRAVEL RELEASE

I/We do ______, do not ______, give consent for (name of child) ______________________________ to participate in field trips with the above named program. I/We do reserve the right to be notified before each field trip that involves travel out of town. I release the program of any liability unless negligence is proven.

Restrictions:

_______________ ____

Date Signature of Parent or Legal Guardian

PHOTOGRAPHY/VIDEOTAPING RELEASE

I/We do ______, do not ______, give consent that the above named program may take photographs/videotapings of our child (name of child) ______________________________________, and I/we consent that the program may use the photographs/videotapes of our child in promoting the purpose of the Center. We understand that no financial benefits from the use of the photographs/videotapes are obligated to be paid to us.

Restrictions:

_______________ ____

Date Signature of Parent or Legal Guardian

SCHOOL-AGE TRAVEL TO AND FROM SCHOOL NOTIFICATION

I/We understand that my child will be transported with only one adult in a center-owned vehicle for the sole purpose of transporting children to and from school. My child will be transported to and from (name of school) ____.
This includes days in which there is early release/late starts at the school. I affirm that my child's participation in the transportation program is entirely my choice, with the understanding of risk or accidental injuries that may be involved in any transportation program in the Center.

_______________ ____

Date Signature of Parent or Legal Guardian

LITTLE HOME LEARNING CENTER
Box 123
LOWDEN, IA 52255
563-941-7790

PICK-UP AUTHORIZATION FORM

CHILD'S FULL NAME: ____

CHILD'S AGE: ____________

I hereby give permission for my child to leave the center with the following persons identified below. It is my responsibility to notify the center in writing of any changes to this authorization.

Name	Address	Phone no.	Relationship to child

Is there a court order prohibiting contact with my child by any person?
___YES ___NO If 'Yes' please provide photocopy of order.

Name of prohibited person_________________________ Relationship____________

Is there any child custody order of which we need to be aware? _______________

If so, please advise: ____

Name(s) of person(s) who may not pick up my child:

____

____

____

Signature(s) of Parent(s) or Guardian Date

Form A.

Iowa CACFP Child Care Center Parent/ Guardian Letter - Non-pricing (front) Rev. 7/14

Purpose: The attached Iowa Eligibility Application is used to determine eligibility for free and reduced price meal reimbursement. The instructions for completion are on the back of this letter.
Instructions to centers: Choose Form A if you do not have a separate charge for meals. Copy this letter (front and back) and staple to each Iowa Eligibility application that is distributed to families of enrolled participants.

Dear Parent or Guardian:

This center participates in the Child and Adult Care Food Program (CACFP) administered by the United States Department of Agriculture (USDA). Participants are not charged separately for meals. However, by participating in this Program, the center receives partial reimbursement for nutritious meals served to children. The amount of reimbursement the center receives is determined by the information you provide. Providing information can help your center purchase nutritious food. Higher reimbursement will be given to the center for meals served to enrolled children from families whose income is at or below the level shown in the chart below. Please read the instructions on the back, complete, sign and return the attached income application as soon as possible. An application that does not contain all required information cannot be used by the center. If required information is missing, free or reduced-price meal benefits will be denied. Call your center if you need help with the form. The information reported on this form will be filed and treated as confidential.

A foster child who is the legal responsibility of a welfare agency or court may be certified as eligible for free meals regardless of your household income. See instructions on the back for more information.

If you do not qualify now to receive free or reduced price meals, you may apply for benefits at any time during the year. If you have a decrease in household income, have an increase in family size or have enrolled children that become eligible for food assistance or FIP, you may fill out an application at that time.

Income Eligibility Guidelines for Reduced Price Meals
Effective 7-1-2014 to 6-30-2015

	Yearly	Monthly	Twice per Month	Every Two Weeks	Weekly
1	21,590	1,800	900	831	416
2	29,101	2,426	1,213	1,120	560
3	36,612	3,051	1,526	1,409	705
4	44,123	3,677	1,839	1,698	849
5	51,634	4,303	2,152	1,986	993
6	59,145	4,929	2,465	2,275	1,138
7	66,656	5,555	2,778	2,564	1,282
8	74,167	6,181	3,091	2,853	1,427
For each additional family member add:	+7,511	+626	+313	+289	+145

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. The last four digits of the social security number of the adult household member who signs the application must be listed. The social security information is not required when you apply on behalf of a foster child or if you list a Food Assistance number, or Family Investment Program number, or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the CACFP. We may share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

USDA Non-Discrimination Statement: The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital Status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)
If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html. Or at any USDA office, or call (866)632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202)690-7442 or email at program.intake@usda.gov.
Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).
Iowa Non-Discrimination Notice: It is the policy of this CNP provider not to discriminate on the basis of race, creed, color, sex, sexual orientation, gender identity, national origin, disability, or religion in its programs, activities, or employment practices as required by the Iowa Code section 216.7and 216.9. If you have questions or grievances related to compliance with this policy by this CNP Provider, please contact the Iowa Civil Rights Commission, Grimes State Office Building, 400 E. 14th St., Des Moines, IA 50319-1004; phone number 515-281-4121, 800-457-4416; web site: https://icrc.iowa.gov.

Instructions for Completing Iowa Eligibility Application

Complete both sides of an application for each household.

Part 1. All applicants should complete this part. This application may be used to apply for benefits in school meals or milk programs, child care centers and home based care for children. Check all boxes that apply to your family. You may make copies of a completed application for each program in which your child participates.

Part 2. Check if any child is Homeless, Migrant, or a Runaway. Then call your child's school.

FIP or FOOD ASSISTANCE HOUSEHOLD MEMBER, including child(ren) in Head Start or Even Start, follow these instructions.

Part 3. List one FIP or Food Assistance **Case Number** per household in the area provided. **Use the Home Case Number listed in the DHS Notice of Decision**. Eligibility based on Head Start or Even Start is available only if your child is enrolled in Head Start and documentation from the Head Start agency is provided. **NOTE: Medicaid, Title XIX and EBT card numbers are not acceptable.**

Part 4, List the name, date of birth, grade (if applicable), name of school/Head Start/child care center attended for each child in your household Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your child's ethnic and racial status if you do not complete this section.

Part 5. Skip this section.

Part 6. Read the certification and complete this section.

FOSTER CHILD IN HOUSEHOLD, follow these instructions. A foster child is a child who is living with a household but who remains the legal responsibility of the welfare agency or court. Foster children can be included as household members or included on a separate application.

Part 4. List the child's name, date of birth, grade (if applicable), name of school/Head Start/child care center attended. Check the box for foster child. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your foster child's ethnic and racial status if you do not fill this section.

Part 5. Complete this section only if the foster child receives money for personal use or has other regular personal income. If the foster child has no income, check the box indicating no income. DO NOT include the stipend received by the foster family to provide care to the foster child.

Part 6. Read the certification and complete this section.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions for reporting income.

Part 4. List the name, date of birth, grade (if applicable), name of school/Head Start/child care center/home attended for each child in your household. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of each child's ethnic and racial status if you do not complete this section.

Part 5. Follow these instructions to report total household income from last month.

- **Name:** List the last and first names of **each** person living in your household, related or not (such as grandparents, other relatives, or friends); include yourself and all children living with you. The household decides whether to include the foster child on their household application with non-foster children. Attach another sheet of paper if needed.
- **Age:** List the age of each household member.
- **Check if No Income:** Put a mark in the box if the household member **does not** have an income.
- **Gross Income last month and how it was received:** Report the amount of income received in the appropriate Gross Income column (weekly, every 2 weeks, twice monthly, or monthly). List the **gross income** each person earned from work. This is not the same as take-home pay. **Gross Income is the amount earned before taxes and other deductions.** The amount should be listed on your pay stub, or your boss can tell you. If you have a household member for whom last month's income was higher or lower than usual, list that person's expected average income. If the household includes the foster child, they must report any personal income received by the foster child on the foster parent's household application.
- **Other Monthly Payments or Income:** Money is reported in this section if it is regularly received. List the amount each person received last month from welfare, child support, alimony, adoption subsidies, pensions, retirement, Social Security, Supplemental Security Income (SSI), and Veteran's benefits (VA benefits). In the **All Other Income** column, include Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, cash withdrawn from savings, investments or trusts, interest and **ANY OTHER INCOME**. Use the Self-Employment Income Worksheet on the back of the application to calculate net income for self-owned businesses, farm, or rental income and report in the **All Other Income** column. **Do not report**: Scholarships, educational benefits, lump sum payments, combat pay, Deployment Extension Incentive Pay (DEIP) or children's incidental income from occasional activities such as babysitting, shoveling snow, or cutting grass. If you are in the Military Housing Privatization Initiative or get combat pay do not include these allowances.
- **Social Security Number:** If the application is being made on the basis of income, the adult signing the form must provide the last 4 digits of his or her Social Security number or mark the "I do not have a Social Security number" box. If you do not provide your Social Security information or mark the box, your application cannot be processed.

Part 6. Read the certification and complete this section.

Received Date: _______

Iowa Eligibility Application

FFY 14-15

Complete one application per household. School Year 2014-2015

Part 1. Check all applicable boxes: ☐ school meals ☐ special milk (restrictions apply) ☐ children in child care center ☐ Tier I home provider (HP) ☐ Head Start/Even Start ☐ children in child care home(HP) Provider name:

Part 2. FIP or Food Assistance Eligible: Enter the FIP or Food Assistance Case Number for ANY household member as listed in the Notice of Decision. NOTE: Medicaid, Title XIX and EBT card numbers are not acceptable. Skip part 5.

Name of household member with Case Number ________________ **List Case Number** ________________

Part 3. Check if any child is Homeless, Migrant, or a Runaway and call your child's school. ☐ Run away ☐ Migrant ☐ Homeless

Part 4. Children enrolled. REQUIRED OF ALL APPLICANTS.

List name(s) of all enrolled child(ren) in your household.

Ethnicity: H=Hispanic or Latino, N=Non Hispanic or Latino

Race: A=Asian B=Black or African American I=American Indian or Alaska Native P=Native Hawaiian or other Pacific Islander W=White

Last Name	First Name	Middle Name or Initial	Check box for FOSTER child	Date of Birth	Grade	OPTIONAL Schools Only: ETHNICITY	RACE	Name of School/Head Start/ Child Care Center/Home
1.			☐					
2.			☐					
3.			☐					
4.			☐					
5.			☐					

Part 5. Total Household Gross Income. DO NOT COMPLETE PART 5 IF YOU LISTED A FIP OR FOOD ASSISTANCE NUMBER IN PART 3. Report the gross income received by EACH household member one time in the correct column: weekly, every 2 weeks, twice a month or monthly. Gross income is the amount earned before taxes and other deductions, not take-home pay. Report all other monthly income received. Self-employed persons, see the worksheet on reverse side of this application.

List the names of everyone living in your household, including the children listed in Part 4. Attach a separate page if more space is needed. For FOSTER children, include only money available for child's personal use or child's own income.

Last Name	First Name	Age	Check if NO Income	Gross Income: Report income by how often the household member is paid. Gross amount earned weekly	Gross amount earned every 2 weeks	Gross amount earned twice a month	Gross amount earned monthly	Other Monthly Payments or Income Received. Welfare, child support, alimony, adoption subsidies	Pension, retirement, social security, SSI, VA benefits	All other income
1.			☐							
2.			☐							
3.			☐							
4.			☐							
5.			☐							

Last four digits of my Social Security Number: X XX - X X - ___ ___ ___ ___ ☐ I do **not** have a Social Security Number.
If Part 5 is completed, the adult signing the form must provide the last 4 digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. **For further information refer to the Privacy Act Statement in the parent letter.**

Part 6. Certification and Signature. REQUIRED OF ALL APPLICANTS.
I certify (promise) that all information on this application is true and that all income is reported if required. I understand that I will receive benefits from Federal funds based on the information I give. I understand that officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal/milk benefits, and I may be prosecuted. Email of Adult completing Form ________________

Signature of Adult Completing Form ________ Printed Name of Adult Completing Form ________ Date Signed ________

Address of Adult Completing Form ________ Town ________ ZIP Code ________ Work Phone ________ Home Phone ________ Cell Phone ________

Part 7. DO NOT WRITE BELOW THIS LINE. FOR ADMINISTRATIVE USE ONLY.
Income conversion factors for annual income: weekly X 52; two weeks X 26; twice a month X 24; monthly X 12
Household Income: $ ________ ☐ Weekly ☐ Every 2 Weeks ☐ Twice Monthly ☐ Monthly ☐ Annually Household Size ______

Application Approved: ☐ Income ☐ Foster Child (free) ☐ FIP/Food Assistance
☐ Head Start DOCUMENTATION REQUIRED
☐ Homeless/Migrant/Runaway (Schools only) -Local Official Documentation Required

Eligibility Determination: ☐ Free Meals ☐ Reduced Price Meals ☐ Free Milk
Application Denied: ☐ Incomplete ☐ Over income limits

CACFP HP ONLY:
☐ Tier 1 Area (Provider's own children)
☐ Tier 1 Income (All children)
☐ Tier 1 Child (Tier 2 mixed)

Confirming Official Signature (Schools only) ________ **Date** ________

Determining Official Signature ________ **Effective Date** ________

Follow-Up Official Signature (Schools only) ________ **Date** ________

Your child is enrolled for care in a child care center that participates in the Child and Adult Care Food Program (CACFP). By participating in this Program, the center is meeting Federal meal pattern requirements and receiving reimbursement to assist with food costs. The CACFP requires that parents provide CACFP enrollment information on an annual basis. This form will be placed in our files and treated as confidential information.

Revised 6/2014

Iowa Child and Adult Care Food Program
Child Care Enrollment Form

Last Name, First Name	Date of Birth	Times of Care		Regular Days of Care							Meals Served During Care						Ethnicity/Race*	
		Arrival	Departure	M	T	W	Th	F	S	S	B	AM Sn	Lu	PM Sn	D	E Sn	Ethnicity	Race

*Ethnicity (Select one and enter in the chart above): H=Hispanic or Latino or N=Not Hispanic or Latino
Race (Select one or more and enter in the chart above): W=White, B=Black or African American, I=American Indian or Alaska Native, A=Asian, and P=Pacific Islander
This information is requested by the Federal Government in order to monitor compliance with civil rights law. You are not required to furnish this information, but are encouraged to do so. The law requires that a program recipient may neither discriminate on the basis of this information nor on whether you choose to furnish it. However, if you choose not to furnish it, under Federal regulations, this program representative is required to note race/ethnicity on the basis of visual observation or surname.

Infants only (0 to 12 months): ☐ I am not enrolling an infant (skip this section)

As a participant in a USDA Child Nutrition Program, our center offers meals to children of all ages. Infant feeding is based on current nutrition guidelines. Infant foods are appropriate for the age and developmental readiness of your infant. Please select (X) your choice(s) of 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 feedings if necessary: ☐Yes ☐No

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

☐ I accept the center's formula for my infant. Name of formula: ____________

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

☐ I accept the center's solid foods (appropriately textured) to be served to my infant as s/he is ready for them, and after I have discussed it with the caregiver.

☐ I will provide solid foods for my infant*. The center may supplement with additional solid foods when my infant needs them: ☐Yes ☐No

*Meals cannot be reimbursed by the CACFP when parents provide solid foods except for medical reasons. DHS licensed centers are required to follow CACFP infant meal pattern requirements regardless of who supplies the food. Your center can provide a copy of the CACFP infant meal pattern and a list of reimbursable foods upon request.

Parent Signature____________________ Date:__________

Parent Signature____________________ Date:__________ (Make any needed changes above, sign and date)

Parent Signature____________________ Date:__________ (Make any needed changes above, sign and date)

USDA is an equal opportunity provider and employer.

This form is available in Spanish in "Form Download" (on the website where claims are submitted)

IDPH

Iowa Department of Public Health
Certificate of Immunization

LITTLE HOME LEARNING CENTER
Box 123
LOWDEN, IA 52255
563-941-7790

Name Last: ______________________ First: ______________ Middle: ______________ Date of Birth: ______________

Parent/Guardian: ______________ Address: ______________________________ Phone: (____)______________

I certify that the above named applicant has a record of age-appropriate immunizations that meet the requirement for licensed child care or school enrollment.

Signature: ______________________________ Date: ______________

Physician, Physician Assistant, Nurse, or Certified Medical Assistant

A representative of the local Board of Health or Iowa Department of Public Health may review this certificate for survey purposes.

	Vaccine	Date Given	Doctor / Clinic / Source
Diphtheria, Tetanus, Pertussis DTaP/DTP/DT/ Td/Tdap			
Polio IPV/OPV			
Measles, Mumps, Rubella MMR			
***Haemophilus influenzae* type b** Hib			
Hepatitis B			

	Vaccine	Date Given	Doctor / Clinic / Source
Varicella Chicken Pox If patient has a history of natural disease write "Immune to Varicella"			
Pneumococcal PCV/PPV			
Meningococcal MCV4/MPSV4			
Hepatitis A			
Rotavirus			
Human Papilloma Virus HPV			
Other			

Infant, Toddler, Preschool Age – Child Health Exam Form

PARENTS/GUARDIAN COMPLETE PAGES 1 and 2 – Child Information

Child's name	Child's birthdate	Name of center, provider, or preschool Telephone #

Parent 1 name	Parent 2 name

Child home address #1	Telephone # 1
Child home address #2	Telephone #2

Where parent # 1 works	Work address	Home phone # Work # Pager # Cellular # Home email Work email
Where parent # 2 works	Work address	Home phone # Work # Pager # Cellular # Home email Work email

In the event of an emergency, the child care provider is authorized to obtain EMERGENCY MEDICAL or DENTAL CARE even if the child care center is unable to immediately make contact with the parent/guardian. ☐ **YES** ☐ **NO**

During an emergency the child care provider is authorized to contact the following person when parent or guardian cannot be reached.

Parent/Guardian Signature: ______________________________ Date ____________

Alternate emergency contact person's name:______________________ Phone number:

Relationship to child: Cellular number:

Child's doctor's name	Doctor telephone # 1	Hospital choice
Doctor's address	After hours telephone #	Does child have health insurance? ☐Yes, Company ____________ **ID #**
Child's dentist's name	Dentist Telephone # 1	Does child have dental insurance? ☐Yes, Company ____________ **ID#**
Dentist's Address	After hours telephone #	☐ **NO, we do not have health insurance.** ☐ **NO, we do not have dental insurance.**
Other health care specialist name Type of specialty	Telephone #	☐ **Please help us find health or dental insurance.**

Child Name:

PARENTS COMPLETE THIS PAGE

Parents: Tell us about your child's health. Place an **X** in the box ☒ if the sentence applies to your child. Check *all* that apply to your child. This will help your doctor plan your child's physical exam.

Growth

☐ I am concerned about my child's growth.

Appetite

☐ I am concerned about my child's eating / feeding habits or appetite.

Rest -

☐ I am concerned about the amount of sleep my child needs.

Illness/Surgery/Injury - My child

☐ had a serious illness, injury, or surgery.

Please describe.

Physical Activity - My child

☐ must restrict physical activity.

Please describe.

Development and Learning

☐ I am concerned about my child's behavior, development, or learning.

Please describe:

☐ **Medication** - My child takes medication

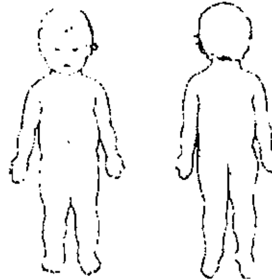
List the name, time medication taken, and the

Child's Name: ______________________________

Body Health - My child has problems with

☐ Skin, birthmarks, Mongolian spots, hair, fingernails or toenails.

Map and describe color/shape of skin markings birthmarks, scars, moles



☐ Eyes \ vision, glasses

☐ Ears \ hearing, hearing aides or device, earaches, tubes in ears

☐ Nose problems, nosebleeds, runny nose

☐ Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring

☐ Frequent sore throats or tonsillitis

☐ Breathing problems, asthma, cough, croup

☐ Heart, heart murmur

☐ Stomach aches, upset stomach, colic, spitting up

☐ Using toilet, toilet training, urinating

☐ Bones, muscles, movement, pain with moving

☐ Mobility, uses assistive equipment

☐ Nervous system, headaches, seizures, or nervous habits (like twitches)

☐ Needs special equipment. *Please describe:*

☐ **Allergies**-My child has allergies (medicine,

Please describe:

Parent questions or comments for the health care provider:

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

HEALTH PROFESSIONAL COMPLETE THIS PAGE[1]

Child's Name: ______________________

Birthdate: **Age today:**

Date of Exam:____________

Height/Length:

Weight:

Head Circumference-for children age 2 yr and under:

Blood Pressure-start @ age 3 yr:

Hgb or Hct-anytime between 6-9 mo:

Blood Lead Level-start @ 12 mo:

Sensory Screening:

Vision: Right eye ________ Left eye ________

Hearing: Right ear ________ Left ear ________

Tympanometry (may attach results)

Developmental Screening[2]**:**

Developmental screening results:

Autism screening results:

Psychosocial/behavioral results

Developmental Referral Made Today: ☐Yes ☐No

Exam Results: *(n = normal limits) otherwise describe*

HEENT

Oral/Teeth

Oral Health/Dental Referral Made Today: ☐Yes ☐ No

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Immunization: May attach a copy of Iowa Department of Public Health Immunization Certificate

DtaP/DTP/Td	MMR
Hepatitis B	Pneumococcal
HIB	Varicella
Polio	Other
Influenza	

TB testing (only for high-risk child)

Medication: Health professional authorizes the child may receive the following medications while at child care or preschool: (include *over-the-counter* and *prescribed*)

Medication Name	Dosage
☐ Cough medication	
☐ Diaper crème:	
☐ Fever or Pain reliever:	
☐ Sunscreen:	
☐ Other	

Other Medication should be listed with written instructions for use in child care.

Referrals made:

☐ Referred to ***hawk-i*** today 1-800-257-8563

☐ Other: ______________________________

Health Provider Assessment Statement:

☐The child may participate in developmentally appropriate child care/preschool with ***NO*** health-related restrictions.

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

Signature ______________________________

Circle the Provider Credential Type: MD DO PA ARNP

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[1] 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

[2] Developmental screening procedures were expanded to include autism, developmental surveillance, and psychosocial/behavioral screening July 2009 by the Iowa EPSDT Medicaid program. Toll-free 800-383-3826.

Health Care Provider comments or instructions:	**Child's name:** ____________________

Iowa Health Care Provider -- Guide to Iowa Recommendations for Preventive Pediatric Health Care[3]

Health Provider's Guide		AGE[4]											
		1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	2 yr	3 yr	4 yr	5 yr
History:	Initial and Interval	●	●	●	●	●	●	●	●	●	●	●	●
Physical Exam		●	●	●	●	●	●	●	●	●	●	●	●
Measurement:	Height/ Weight	●	●	●	●	●	●	●	●	●	●	●	●
	Head Circumference	●	●	●	●	●	●	●	●	●			
	Blood Pressure	Risk Assessment									●	●	●
Nutrition	Assess/Educate	●	●	●	●	●	●	●	●	●	●	●	●
Oral Health Assessment[5]		●	●	●	●	●	●	●	●	●	●	●	●
Development and Behavioral Assessment		●	●	●	●	●	●	●	●	●	●	●	●
	Developmental Screening					●			●		●		
	Autism Screening								●	●			
	Developmental Surveillance	●	●	●	●		●	●		●		●	●
	Psychosocial/behavioral Assessment	●	●	●	●	●	●	●	●	●	●	●	●
Sensory Screen:	Vision	S	S	S	S	S	S	S	S	S	O	O	O
	Hearing[6]	S	S	S	S	S	S	S	S	S	S	O	O
Immunizations:	*per Iowa schedule*[7]	●	●	●	●	●	●	●	●	●	●	●	●
Lab:	Hemaglobinopathy/Metabolic Screen	●[8]											
	Hematocrit or Hemoglobin					● →	→	◆ →	→	→	→	→	→
	Urinalysis												●
	Lead Test						●		◆	●[9]	◆	◆	◆
	Cholesterol Screen									◆ →	→	→	→
	TB test[10]						◆	→	→	→	→	→	→
Family Guidance:	Injury Prevention	●	●	●	●	●	●	●	●	●	●	●	●
	Child Car Seat Counseling	●	●	●	●	●	●	●	●	●	●	●	●
	Tricycle Helmet Counseling									●	●	●	●
	Sleep Position Counseling	●	●	●	●	●	●						
	Nutrition & Physical Activity Counseling	●	●	●	●	●	●	●	●	●	●	●	●
	Violence Prevention	●	●	●	●	●	●	●	●	●	●	●	●
	Child Development Guidance	●	●	●	●	●	●	●	●	●	●	●	●
		1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	2 yr	3 yr	4 yr	5 yr

Key: ● = to be performed
◆ = to be performed for high-risk children
→ = Range in which the task may be completed

S = Subjective, by history
O = Objective, by standard testing

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[3] The periodicity schedule was revised July 2009 by the Iowa Medicaid EPSDT program. http://www.idph.state.ia.us/hpcdp/epsdt_care_for_kids.asp

[4] If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

[5] Oral Health Assessment consists of dental history; recent concerns, pain or injury; visual inspection of hard and soft tissues of oral cavity; and dental referral based on risk assessment. http://www.idph.state.ia.us/hpcdp/oral_health.asp or toll-free: 866-528-4020.

[6] Infants born in Iowa should have record of results from newborn hearing screening. http://www.idph.state.ia.us/iaehdi/default.asp or toll-free 800-383-3826.

[7] Iowa Immunization program 1-800-831-6293.

[8] All newborns should receive metabolic screening during neonatal period. www.idph.state.ia.us/genetics

[9] Lead testing should be done at 12 & 24 months. Testing may be done at additional times for children determined at risk.
Lead program 1-800-972-2026.

[10] TB testing for only at-risk children, Iowa TB program 1-800-383-3826.