INSTRUCTIONS FOR FILLING OUT REQUIRED FORMS

ALL INFORMATION MUST BE COMPLETE
FOR YOUR CHILD TO ATTEND PRESCHOOL

The forms that you are being asked to complete are necessary for your child to attend preschool. They not only are required by DHS, but they also are essential for the health and safety of everyone attending preschool. Please take a few moments to carefully complete each form. The following provides some guidelines:

PARENTAL EMERGENCY MEDICAL CONSENT FORM – CHILD HEALTH EXAM FORM P. 1 & 2

- **Pages 1 and 2** need to be completed in full, including physicians' names and phone numbers. All the following is **required:**
  * **Names/Numbers/Addresses of Parents or Guardians**: **Include** all numbers (home, work, cell) at which you can be reached.
  * **Emergency Contact Name: Include** all information, including relationship to your child.
  * **Physician: Include** Name, Address (**INCLUDING street number**), Telephone; *if the clinic is located in UIHC, we need to know which clinic (peds, family care center, etc.)*.
  * **Dentist**: Include** Name, Address (**INCLUDING street number)**, Telephone; *if the clinic is located in UIHC, we need to know which clinic (college of dentistry)*.
- **Sign and Date the Form**; you may date the form using the date that your child will start.

** *In the past, we've had parents tell us that their child does not have a dentist yet, or that they plan on always being available, thus don't feel the need to include an emergency contact person. However, we absolutely need this information, and your child will not be able to attend without it.*

PHYSICAL– CHILD HEALTH EXAM FORM P. 3 ***

- **New Students:** We need a **complete physical signed and dated by the doctor (p. 3 of the Child Health Exam Form)**. The physical needs to have occurred within the last year.
- **Returning Students: The Health Provider Assessment Statement on p. 3 of the Child Health Exam Form is needed.** Please make sure the form is **signed and dated by the doctor**.

*** *Physicals need to be updated annually, so if you know your child is due at any time during the year, please ask for a form.*

VACCINATIONS

- Your child needs to have an updated and valid vaccination record form or a waiver.

TRAVEL CONSENT

- **Sign and Date the consent for field trip travel**. Before any field trips are taken, you will be informed.

AUTHORIZATION FOR PICK-UP (BACK OF TRAVEL CONSENT)

- **Include** the names, telephone numbers, and relationship to your child of all persons who may be picking up your child.
- **Sign and Date.**

Infant, Toddler, Preschool Age – Child Health Exam Form

PARENTS 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 parents/guardian. During an emergency the child care provider is authorized to contact the following person when parent or guardian can not be reached.

Parent/Guardian Signature: _____ Date _____

Alternate emergency contact person's name: Relationship to child: Phone number:

Child's doctor's name	Doctor telephone # 1	Hospital choice
Doctor's address	After hours telephone #	Does your child have health insurance? ☐Yes, Company _____ **ID #**
Child's dentist's name	Dentist Telephone # 1	Does your 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 **Child's Name: _____**

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.

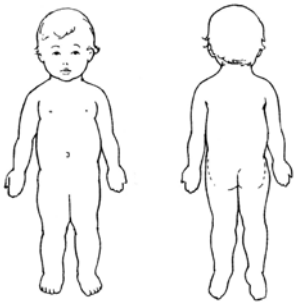
Illness/Surgery/Injury - My child
☐ has had a serious illness, surgery, or injury. *Please describe.*

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 meds taken at home, preschool, or in child care. List the name, time medication taken, and the reason medication prescribed.

Body Health - My child has problems with
☐ Skin, birthmarks, Mongolian spots, hair, fingernails or toenails.
Map and describe any skin markings



☐ 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 (food, medicine, fabric, inhalants, insects, animals, etc.). Please describe.

Parent questions or comments for the health care provider:

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

DOCTORS COMPLETE THIS PAGE[1]

Child's Name:

Birthdate: **Age today:**

Date of Exam:

Height or Length:

Weight

Head Circumference (for children **under** 2 yr.):

Body Mass Index (for children **over** 2 yr.):

Blood Pressure (start @ age 3 yr.):

Hgb. or Hct.: (start @ 1 yr.)

Blood Lead Level: (start @ 1 yr.)

Sensory Screening:

Vision Right eye _____ Left eye _____

Hearing Right ear _____ Left ear _____

Tympanometry (attach results)

Developmental Screening:

Personal-Social

Fine Motor-Adaptive

Language

Gross Motor

Developmental Referral Made Today: □Yes □No

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

HEENT

Oral/Teeth

Date of Last **Dental** Exam: _____
Dental Referral Made Today: ☐Yes ☐ No

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Space is available on back page for detailed physician comments or instructions.

[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

Immunization: Doctor may attach a copy of Iowa Department of Public Health Immunization Certificate

DtaP/DTP/Td

Hepatitis B

HIB

Influenza

MMR

Pneumococcal

Polio

Varicella

Other

TB testing (for high risk child only)

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

Medication Name Dosage

☐ Diaper crème:

☐ Pain reliever:

☐ Sunscreen:

☐ Cough medication

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

Referrals made:

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

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 these restrictions***:

May use stamp

Doctor Signature _____

Circle the Provider Credential Type: MD DO PA ARNP

Address: Telephone:

Health Care Provider comments or instructions:

Health Care Provider -- Guide to Iowa Recommendations for Preventive Pediatric Health Care

Health Provider's Guide	AGE[2]											
	1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3 yr	4 yr	5 yr
History: Initial and Interval	●	●	●	●	●	●	●	●	●	●	●	●
Measurement: Height/ Weight	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference	●	●	●	●	●	●	●	●	●			
Blood Pressure										●	●	●
Sensory Screen: Vision	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**O**	**O**	**O**
Hearing	**O**	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**O**	**O**
Developmental Screening	●	●	●	●	●	●	●	●	●	●	●	●
Complete Unclothed Physical Exam	●	●	●	●	●	●	●	●	●	●	●	●
Lab: Hereditary/Metabolic Screen	●[3]											
Hematocrit or Hemoglobin					●	→	◆	→	→	→	→	→
Urinalysis												●
Lead Test						●		◆	●[4]	◆	◆	◆
Cholesterol Screen									◆	→	→	→
TB test[5]						◆	→	→	→	→	→	→
Immunizations: *per Iowa schedule*[6]	●	●	●	●	●	●	●	●	●	●	●	●
Family Guidance: Injury Prevention	●	●	●	●	●	●	●	●	●	●	●	●
Child Car Seat Counseling	●	●	●	●	●	●	●	●	●	●	●	●
Tricycle Helmet Counseling									●	●	●	●
Sleep Position Counseling	●	●	●	●	●	●						
Nutrition & Physical Activity Counseling	●	●	●	●	●	●	●	●	●	●	●	●
Violence Prevention	●	●	●	●	●	●	●	●	●	●	●	●
Child Development Guidance	●	●	●	●	●	●	●	●	●	●	●	●

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

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

[2] 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.

[3] All newborns should receive metabolic screening (e.g. Thyroid, hemoglobinopathies, PKU, galactosemia) during neonatal period.

[4] Lead testing should be done at 12 & 24 months, Testing may be done at additional times for children determined at risk. Lead program 1-800-242-2026.

[5] TB testing for only at-risk children, Iowa TB program 1-800-383-3826. [5] . Iowa Immunization program 1-800-831-6293.

Iowa Department of Public Health
Certificate of Immunization

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			
Varicella Chicken Pox If applicant has a history of natural disease write "Immune to Varicella"			
Pneumococcal *PCV/PPV*			

	Vaccine	Date Given	Doctor / Clinic / Source
Meningococcal *MCV4/MPSV4*			
Hepatitis A			
Rotavirus			
Human Papilloma Virus *HPV*			
Other			

Licensed Child Care Requirements

4 through 5 months
- **1 dose Diphtheria/Tetanus/Pertussis**
- **1 dose Polio**
- **1 dose Hib**
- **1 dose Pneumococcal**

6 through 11 months
- **2 doses Diphtheria/Tetanus/Pertussis**
- **2 doses Polio**
- **2 doses Hib**
- **2 doses Pneumococcal**

12 through 18 months
- **3 doses Diphtheria/Tetanus/Pertussis**
- **2 doses Polio**
- **2 doses Hib** or 1 dose received at ≥ 15 months of age.
- **3 doses Pneumococcal** if received 1 or 2 doses < 12 months of age; or 2 doses if received 1 dose ≥ 12 months of age or has not received this vaccine before.

19 through 23 months
- **4 doses Diphtheria/Tetanus/Pertussis**
- **3 doses Polio**
- **3 doses Hib** with the final dose in the series ≥ 12 months of age, or 1 dose received ≥ 15 months of age.
- **1 dose Measles/Rubella** ≥ 12 months of age.
- **1 dose Varicella** ≥ 12 months of age if born on or after September 15, 1997, or a reliable history of natural disease.
- **4 doses Pneumococcal**; or 3 doses if received 1 or 2 doses < 12 months of age; or 2 doses if received 1 dose ≥ 12 months of age or has not received this vaccine before.

24 months and older

Same requirements as the 19-23 months except **4 doses Pneumococcal** if received 3 doses < 12 months of age; or 3 doses if received 2 doses < 12 months of age; or 2 doses if received 1 dose < 12 months of age or received 1 dose between 12 and 23 months of age; or 1 dose if no doses had been received prior to 24 months of age.

Elementary/Secondary School Requirements

4 years of age and older
- **5 doses Diphtheria/Tetanus/Pertussis** with at least 1 dose received ≥ 4 years of age if born on or after September 15, 2003; or 4 doses, with 1 dose received ≥ 4 years of age if born after September 15, 2000, but before September 15, 2003; or 3 doses, with 1 dose received ≥ 4 years of age if born on or before September 15, 2000.
- **4 doses Polio** with 1 dose received ≥ 4 years of age if born on or after September 15, 2003; or 3 doses, with 1 dose received ≥ 4 years of age if born on or before September 15, 2003.
- **2 doses Measles/Rubella**; the first dose shall have been received ≥ 12 months of age; the second dose shall have been received ≥ 28 days after the first.
- **3 doses Hepatitis B** if born on or after July 1, 1994.
- **2 doses Varicella** ≥ 12 months of age if born on or after September 15, 2003; or 1 dose received ≥ 12 months of age if born on or after September 15, 1997, but before September 15, 2003, unless the applicant has a reliable history of natural disease.

Rev. 12/2008

Preucil School of Music Preschool
Pick-up Permission Form

Child's Full Name:_____

I hereby give permission for my child to leave the Preucil School of Music Preschool with the following persons named below. *I recognize it is my responsibility to notify the school, in writing, of any changes to this list*

Parent's full name:_____
(Or guardian) **Please Print**.

Parent's signature:_____
(Or guardian)

Today's date: _____

Name:	**Relationship**:	**Phone Number:**
_____	_____	_____
_____	Parent #1	_____
_____	Parent #2	_____
_____	Emergency care person	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
	_____	

If there is a separation or divorce custody problem of which we should be aware, please explain.

Is there anyone who may NOT pick up your child?_____ If so, please explain.

Preucil School of Music Preschool
Travel and Activity Authorization and Release of Liability

I/We, the Undersigned parent(s) or guardian(s) of _____,
(Please print name of student)
consent to the participation of our child in the educational trips planned by the Suzuki Preschool of the Preucil School of Music for the current academic year and following summer session. We understand that transportation for these trips may be by car, by public transportation, or by walking. We, the undersigned, do release and discharge the Preucil School of Music, its officers, employees and volunteers from any liability for injury suffered by the named student in transit to and from and at each activity except for willfeul negligence on the part of the School, its officers and employees.

Parents will be notified before each field trip. Restrictions include:

1. Each person will be secured in a seat belt and/or car seat as required by law for any field trip.

   ADDITIONAL RESTRICTIONS, if any, set by parents.

2. _____

3. _____

_____ _____

Date *Signature of Parent/Guardian*