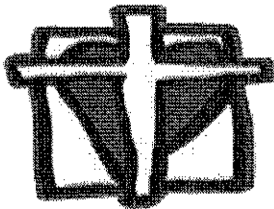


SACRED HEART PRESCHOOL AND CHILDCARE

806 Eddy St. Maquoketa, IA 52060
Phone/Fax Number: 563-652-3743

ENROLLMENT INFORMATION FORM

Circle One: 3-Year Old Preschool Childcare Both

Child's Full Name: ______________________ Nickname (if used): ______________________
Birth Date: ______________ Gender:________ Race:________ Religion:________
Address:______________________________ City/Zip Code:______________________

Mother's Name:______________________________ E-mail:______________________
Address:______________________________ City/Zip Code:______________________
Home Phone:______________ Cell Phone: ______________Work Phone:______________
Employer:______________________ Address:______________________________

Father's Name:______________________________ E-mail:______________________
Address:______________________________ City/Zip Code:______________________
Home Phone:______________ Cell Phone: ______________Work Phone:______________
Employer:______________________ Address:______________________________

Guardian's Name (if applicable):______________________ E-mail:______________
Address:______________________________ City/Zip Code:______________________
Home Phone:______________ Cell Phone: ______________Work Phone:______________
Employer:______________________ Address:______________________________

Parent's Marital Status: ___Married ____Divorced ____Separated _____Single ____Deceased

Are there any custody/restraining orders for persons who may attempt to pick up or have contact with this child while in the care of the Center? Names of persons who MAY NOT pick up this child:
Name:______________________________ Name:______________________________

Sibling's Name	Birth Date	Gender	School Currently Attending	Grade

PICTURE RELEASE: I hereby do___/do not___ give consent to have my child photographed or videotaped for use by the center in newspapers, publicity, advertisement, or for educational purposes.
Restrictions: ____

TRAVEL AND ACTIVITY AUTHORIZATION: I hereby do___/do not___ give permission for my child to leave the above named facility for field trips to special places; and to travel by car, public transportation, or by walking. I understand that I will be notified in advance of each activity.
Restrictions: ____

Parent Signature:______________________________ Date:______________

Parent Signature:______________________________ Date:______________

PARENTAL EMERGENCY MEDICAL CONSENT

This form must be presented upon admission for treatment

Child's Full Name: ______________________ **Birth Date:** ________ **Gender:** ________

In the event that my child (listed above) may require medical and/or surgical care while I am unable to be reached, I hereby give my consent for medical /surgical treatment __________ Hospital, and Dr. ______________ or his/her designee to provide this care. In the event that my child (listed above) may require dental and/or dental surgical care while I am unable to be reached, I hereby give my consent for dental/dental surgical care to __________ Hospital, and Dr. ______________ or his/her designee to provide this care. I agree to pay all the costs and fees contingent on any emergency medical/dental care or treatment for my child, as secured or authorized under this consent. COMMENT: Every effort will be made to notify parents/guardians immediately in case of emergency. This form will be presented upon admission for treatment.

- **Child's Doctor:** __________________ **Address:** __________________ (Street & City) **Phone:** ______________
- **Child's Dentist:** __________________ **Address:** __________________ (Street & City) **Phone:** ______________
- **Known Allergies:** ____
- **Health Concerns :** ____
- **Date of last tetanus:** ____________ **Present medications:** ______________________
- **Parents/Guardians with whom child resides:**

  Name: ______________________ Name: ______________________
  Relationship to child: ______________ Relationship to child: ______________
  Address: ______________________ Address: ______________________
  Home Phone: __________ Cell Phone: __________ Home Phone: __________ Cell Phone: __________
  Work Phone: __________ Work Phone: __________

- **Authorized Persons to Contact in Case of EMERGENCY (if parent is not available):**

  Name: ______________________ Name: ______________________
  Relationship to child: ______________ Relationship to child: ______________
  Address: ______________________ Address: ______________________
  Home Phone: __________ Cell Phone: __________ Home Phone: __________ Cell Phone: __________
  Work Phone: __________ Work Phone: __________

- **I hereby give my permission for my child to be picked up by the following persons, in addition to those stated above. It is the responsibility of the parent to notify the Center (in writing) of any changes.**

  Name: ______________________ Name: ______________________
  Relationship to child: ______________ Relationship to child: ______________
  Address: ______________________ Address: ______________________
  Home Phone: __________ Cell Phone: __________ Home Phone: __________ Cell Phone: __________
  Work Phone: __________ Work Phone: __________

This consent will be in effect for one year beginning ______________ and continue while the child is enrolled in this facility.

Parent Signature: ______________________________ **Date:** ______________

Parent Signature: ______________________________ **Date:** ______________

IOWA SCHOOL-AGE CARE - HEALTH STATUS - PARENT STATEMENT

Parent/Guardian please complete pages 1 and 2.

Child's name	Child's birthdate	Name of school Grade ____ School 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	Telephone # Work # Pager # Cellular # Home email Work email
Where parent #2 works	Work address	Telephone # 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. ☐ **YES** ☐**NO**

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 of choice
Doctor's address	After hours telephone #	Does your child have health insurance? ☐ YES ☐NO Company ____________ **ID#**
Child's dentist's name	Dentist telephone #1	Does your child have dental insurance? ☐ YES ☐NO Company ____________ **ID#**
Dentist's address	After hours telephone #	☐ **Please help us find health or dental insurance.** Call: 800-257-8563
Other medical or dental specialist name **Type of specialty**	Telephone #	Specialist address:
Mental Health care specialist	Telephone #	Specialist address:

Child Name: ____________

IOWA SCHOOL-AGE CARE - HEALTH STATUS - PARENT STATEMENT

Parent/Guardian complete this page

Child name: ____________________

Please use a **X** in the box ☐ to statements that apply to your child.

Date of child's last physical exam: __________
Date of last dental appointment: __________

Growth
☐ I am concerned about child's growth.

Appetite
☐ I am concerned about child's eating habits.

Rest - My child
☐ needs to rest after school.

Illness/Surgery/Injury - My child
☐ Had a serious illness, surgery, or injury.
Please describe:

Physical Activity - My child
☐ Must restrict physical activity or needs special equipment to be active. Please describe:

Play with friends - My child
☐ Plays well in groups with other children.
☐ Will play only with one or two other children.
☐ Prefers to play alone.
☐ Fights with other children.
☐ I am concerned about my child's play activity with other children.

School and Learning - My child
☐ Is doing well at school.
☐ Is having difficulty in some classes.
☐ Does not want to go to school.
☐ Frequently misses or is late for school.
☐ I am concerned about how my child is doing in school. Please describe:

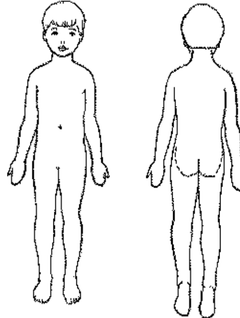
☐ **Allergy** - My child has allergies (list all allergies: food, medicine, fabric, inhalants, insects, animals, etc.):

Child has Epipen, inhaler, or other emergency medication.
☐ Yes ☐ No

Body Health - My child has problems with

☐ Skin, hair, fingernails or toenails.

Describe skin marks, birthmarks, or scars. Show us where these skin marks are located using the drawing below.



☐ Eyes/vision, glasses or contact lenses
☐ Ears/hearing, hearing assistive aides or device, earache, tubes in ears
☐ Nose problems, nosebleeds
☐ Mouth, teeth, gums, tongue, sores in mouth or on lips, breaths through mouth
☐ Frequent sore throats or tonsillitis
☐ Breathing problems, asthma, cough
☐ Heart problems or heart murmur
☐ Stomach aches or upset stomach
☐ Trouble using toilet or wetting accidents
☐ Hard stools, constipation, diarrhea, watery stools
☐ Bones, muscles, movement, pain when moving
☐ Mobility, child uses assistive equipment
Please describe

☐ Nervous system, headaches, seizures, or nervous habits (like twitches or tics)
☐ Females – difficult monthly periods
☐ Other special needs. Please describe:

☐ **Medication**[1] - My child takes medication.

Medication Name	Time Given	Reason for giving medication

Note to parents: ***Certificate of Immunization***
School-owned and operated child care programs located on school property may file/store your child's Certificate of Immunization in the school office or in the school nurse's office.
All other school-age child care programs must keep the Certificate of Immunization on-site at the child care facility.

Parent Signature: (required) **Date:**

[1] Parents: Please review the child care program's policies about the use of medication at child care.