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: _____
Primary Language Spoken in the Home: _____
Language Spoken by Child First Four Years of Life if NOT English _____
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

I herby give permission for my child to be picked up by the following person, in addition to those stated above.

Name: _____ Name: _____
Relationship to child: _____ Relationship to child: _____
Home Phone: _____ Cell Phone: _____ Home Phone: _____ Cell Phone: _____

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:** _____ **Phone:** _____
  (Street & City)
- **Child's Dentist:** _____ **Address:** _____ **Phone:** _____
  (Street & City)
- **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:** _____

Infant, Toddler, Preschool Age – Child Health Form

PARENTS/GUARDIAN COMPLETE PAGES 1 and 2 – Child Information

Child's name	Child's birthdate	Child Care Facility _____ Telephone # _____
Parent/Guardian name #1	Parent/Guardian name #2	
Child home address #1		Telephone # 1
Child home address #2		Telephone #2
Where parent/guardian # 1 works	Work address	Home phone # Work # Cellular # Home email Work email
Where parent /guardian # 2 works	Work address	Home phone # Work # 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 facility 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 # _____

Relationship to child: Cellular # _____

Child's doctor's name	Doctor telephone # 1	Hospital choice **Phone #** _____
Doctor's address	After hours telephone #	Does child have health insurance? ☐Yes, Company _____ **ID #**
Child's dentist's name (or family's dentist 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:

PARENT/GUARDIAN COMPLETE THIS PAGE **Child's Name:** _____

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 health care provider 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:

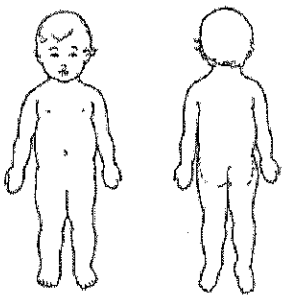
☐ **Allergies**-My child has allergies. (Medicine, food, dust, mold, pollen, insects, animals, etc.).

Please describe:

☐ **Special Needs Care Plan** – My child has a special needs care plan (IEP, IFSP, Asthma Action Plan, Food Allergy Action Plan, etc.). Please discuss with your health care provider.

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, spitting-up
☐ Using toilet, toilet training, urinating
☐ Bones, muscles, movement, pain when moving, uses assistive equipment.
☐ Nervous system, headaches, seizures, or nervous habits (like twitches)
☐ Needs special equipment.

List equipment:

☐ **Medication** - My child takes medication. (List the name of medication, time medication taken, and the reason medication prescribed).

Parent/Guardian questions or comments for the health care provider:

Infant, Toddler, Preschool Age – Child Health Form

HEALTH PROFESSIONAL COMPLETE THIS PAGE

Child's Name: _____

Birthdate: _____ **Age today:** _____

Date of Exam: _____

Height/Length: _____ Weight:_____

BMI– starting at age 24 mo. _____

Head Circumference- age 2 yr. and under: _____

Blood Pressure-start @ age 3 yr:_____

Hgb or Hct- @ 12 mo: _____

Lead Risk Assessment:_____

Blood Lead Level: date_____ results _____

Sensory Screening:

Vison Assessment: _____

Vision Acuity: Right eye _____ Left eye _____

Hearing Assessment: Right ear _____ Left ear _____

Tympanometry (may attach results)

Developmental Screening/Surveillance:
(n = normal limits) otherwise describe

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

Date of Dental exam _____

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

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Health Care Provider comments:

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Immunization: Please attach:

☐ Iowa Department of Public Health Certificate of Immunization

☐ Iowa Department of Public Health Certificate of Immunization Exemption Medical

☐ Iowa Department of Public Health Certificate of Immunization Exemption Religious

☐ TB testing completed (only for high-risk child)

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

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

Other Medication should be listed with written instructions for use in child care. Medication forms available at www.idph.iowa.gov/hcci/products

Referrals made:

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

☐ Other: _____

Health Provider Assessment Statement:

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

☐ The child may participate in developmentally appropriate early care/learning ***with restrictions*** (see comments).

☐ The child has a special needs care plan
Type of plan _____
(please attach)

May use stamp

Signature _____

Circle the Provider Credential Type: MD DO PA ARNP

Address: Telephone:

[1] Iowa Child Care Regulations require an admission physical exam report within the previous year and annually.
The American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures 2015) https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

Child Profile

Child's Name _____

PLAY AND SOCIALITY:

How does your child get along with other children? _____

Are his/her playmates: girls _____ boys _____ younger _____ older _____ none _____

What is the usual size of their neighborhood play group? _____

Previous group experience: preschool _____ play group _____ Sunday School _____

Other comments: _____

_____

PERSONALITY AND EMOTIONAL DEVELOPMENT:

Do you regard your child as: affectionate _____ shy _____ outgoing _____ assertive _____ happy _____

other (please describe) _____

Does he/she accept new people easily? _____

What are your child's fears? _____

What nervous habits does he/she have? _____

How does he/she show them? _____

Other comments: _____

_____

PHYSICAL DEVELOPMENT:

Does your child have any unusual eating problems, food dislikes, or food allergies? _____

_____

What is your child's usual bed time? _____ waking time? _____

What is your child's attitude about bedtime or naptime? _____

Is your child completely toilet trained? _____ How dependable is he/she? _____

How does your child state their need to use the restroom? _____

Do you consider your child to be : right-handed _____ left-handed _____ not sure _____

Other comments: _____

_____

What forms of guidance do you find work with your child? _____

_____

Please add any further information which you believe will be useful in helping us understand your child.

_____

_____

_____