Child Enrollment Information

Child Information			
Child's Name:		**Date of Birth:**	
Address:	**City:**	**State:**	**ZIP:**
Allergies, special instructions, comforting items:			

Parent/Guardian Information (1)			
Name:		**Relationship to child:**	
Address: (if different than child)	**City:**	**State:**	**ZIP:**
Home #:	**Cell #:**	**Work #:**	
Email (personal):		**Email (work):**	
Place of work:		**Address:**	

Parent/Guardian Information (2)			
Name:		**Relationship to child:**	
Address: (if different than child)	**City:**	**State:**	**ZIP:**
Home #:	**Cell #:**	**Work #:**	
Email (personal):		**Email (work):**	
Place of work:		**Address:**	

Emergency Contact (1)			
Name:		**Relationship to child:**	
Address:	**City:**	**State:**	
Home #:	**Cell #:**	**Work #:**	
Email (personal):		**Email (work):**	

Emergency Contact (2)			
Name:		**Relationship to child:**	
Address:	**City:**	**State:**	
Home #:	**Cell #:**	**Work #:**	
Email (personal):		**Email (work):**	

Emergency Contact (3) – Out-of-Area/Out-of-State			
Name:		**Relationship to child:**	
Address:	**City:**	**State:**	
Home #:	**Cell #:**	**Work #:**	
Email (personal):		**Email (work):**	

Medical Information		
Child's Doctor's Name:		**Phone #:**
Address:	**City:**	**State:**
Preferred Hospital to Contact:		**Phone #:**
Address:	**City:**	**State:**

Child's Dentist's Name:		**Phone #:**
Address:	**City:**	**State:**

Does your child have any special needs that I need to be aware of? _____

_____

_____

Persons allowed to pick up my child if I am unable to: **(Also list emergency contacts below if you want to allow them to pick up your child)**		
Name:	**Phone #:**	**Relationship to child:**
Name:	**Phone #:**	**Relationship to child:**
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Name:	**Phone #:**	**Relationship to child:**
Name:	**Phone #:**	**Relationship to child:**
Name:	**Phone #:**	**Relationship to child:**

Any one NOT allowed to pick up my child (with copy of court order, if applicable):

Parent's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

Emergency Medical Treatment Authorization

Permission for medical care in parental absence.

Child's Full Name _____ Birth Date _____

Name child answers to: _____

I, _____ parent or guardian of the child named above give my permission to _____, child care home provider, to secure and authorize such emergency medical care and treatment as my child might require while under the Provider's supervision. I also authorize the Provider 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 <u>immediately</u> 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: _____
Home Phone: _____ Work Phone: _____

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Address: _____
Home Phone: _____ Work Phone: _____

Doctor: _____
Doctor's Address: _____
Doctor's Phone: _____

Preferred Hospital to Contact: _____
Address: _____ Phone: _____

Persons to be contacted in emergency if the parents are unavailable:

Name	Home Phone	Work Phone	Relationship

Present medication(s): _____
Known allergies: _____
Date of last tetanus: _____ Religious Preference: _____
Insurance: _____

Father's signature: _____ Date: _____

Mother's signature: _____ Date: _____

STATE OF IOWA DEPARTMENT OF Health AND Human SERVICES

Infant, Toddler, Preschool Age (including Kindergarten entry)
Child Health Form

HEALTH PROFESSIONAL COMPLETE PAGE

OR PROVIDE COPY OF WELL CHILD PHYSICAL (ANNUALLY)

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 @ 1 yr. & 2 yr.: 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

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Child Name: _____

Date of Birth: _____ **Age:** _____

Immunization and TB Testing: (check as indicated)

☐ IDPH Certificate of Immunization reviewed and signed

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

Health provider authorizes the child may receive the following at child care: (include *over-the-counter medications)*

	Name	Dosage
☐ Diaper cream/ointment:		
☐ Fever or Pain reliever:		
☐ Sunscreen:		
☐ Other		

Prescribed Medication should be listed with written instructions for use in child care. Medication forms available at https://hhs.iowa.gov/hcci/products

Additional Referrals made:

☐ _____

☐ _____

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 complete and give to parent for child care templates at https://hhs.iowa.gov/hcci/products)

Comments:

May use stamp

Signature _____

Circle Provider Type: MD DO PA ARNP Chiropractor

Address: Telephone:

American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures July 2022) https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.153767288.1525543973.1674849857-346854326.1661880588

PARENT/GUARDIAN (COMPLETE THIS PAGE ANNUALLY) **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:

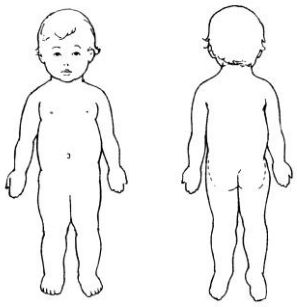
☐ **Allergies** - My child has allergies. (Medicine, food, dust, mold, pollen, insects, animals, etc.).

Please describe:

☐ **Special Needs Care Plan** - My child has a special need and needs a care plan for child care. Please discuss with your health care provider.

☐ **Body Health** - My child has skin problems, birthmarks, Mongolian spots, etc.

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



☐ Eyes \ vision, glasses
☐ Ears \ hearing, hearing aids or device, earaches, tubes in ears
☐ Nose problems, nosebleeds, runny nose
☐ Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring
☐ Nervous System, headaches, seizures
☐ 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.
☐ Needs special equipment.

List equipment:

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

Medication Name	Time Given	Reason for Medication

☐ **Child has Emergency Medication** - Epipen, Respiratory Inhaler, Nebulizer, etc. (Please complete care/action plan) templates at https://hhs.iowa.gov/hcci/products

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

Parent/Guardian Signature (required) _____ Date: _____

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

Photo Release

_____My child may be photographed while in child care. Photos my be used in newspapers or other media for the purpose of publicity or shared with other families whose children attend the child care program.

Parent signature_____

_____I decline the photo release. Do not photograph my child while in the child care program.

Parent signature_____