Dear Parents,

Your child is going to receive an embroidered t-shirt from the preschool. It will be a gray short sleeve with the Share and Care Logo on it. Returning students will receive a different design. Please state below which size your child would wear. They are Gilden shirts and are very good quality of 50 poly/50 cotton that will be embroidered by one of our church members. I do have a sample at school if you want to look at one. The youth sizes are as follows x-small (4-6), small (6-8), medium (10-12), and large (14-16). Thank you!

Amanda Krambeck (Director)

Child's name ______________________________ Size__________

E-mail Address

Please fill out the information listed below so that we have an alternate way of communicating with you. Thank you!

Child's Name______________________________

Class _______MWF AM _______T/Th AM _______5 Day

Parent Name______________________________

E-mail Address______________________________

Parent Name______________________________

E-mail Address______________________________

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:

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

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			

	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			