**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 # |  |  |  | *Child* |  |
|  |  |  |  |  |  |  | Home email |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | *Name:* |  |
|  |  |  |  |  |  |  | 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 insur- |  |  |
|  |  |  |  |  |  |  | ance?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 |  |  | Telephone # | Specialist address: |  |  |  |
|  | **Type of specialty** |  |  |  |  |  |  |  |  |  |  |  |
|  | Mental Health care specialist |  |  | Telephone # | Specialist address: |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |

1 July 2009

Emergency Contacts: (Must have 2 listed other than parents/legal guardians)

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Persons Authorized to take your children from the center:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Persons not authorized to take your child from the center: (must show court order)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of last child care provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List names and ages of siblings: Name Age

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_have received and read the regulations set up by TUG’S Daycare & Preschool and agree to comply with all the rules and responsibilities therein stated.

Start date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weekly schedule: Monday\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Tuesday\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Wednesday\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Thursday\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Friday\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any variation of this schedule must be presented to the TUG’S staff in writing, and approved in order to maintain consistent and adequate staffing.

A $35.00 charge will be made on checks returned due to insufficient funds. After two such checks returned, cash payments will be necessary. TUG’S hours of operation are 6:00 a.m. to 6:00 p.m. Monday – Friday. A $20.00 late fee will be charged to your account if your child/children are picked up after our closing time. Legal action will be taken on all accounts over 60 days past due, and continued attendance will be denied.

TUG’S requires an attendance minimum of 12 hours per week, per school-age child; 35 hours minimum per daycare family.

TUG’S offers families a 2 week vacation allowance per year with no minimum payment required. A two week notice of vacations, in writing, with dates indicated, must be turned into the office in order to ensure proper billing procedures.

Parents will be required to register and/or update your registration annually in late summer before the new school year begins. A $35.00 registration fee per child will be charged upon entering our program. A $25.00/child maintenance fee will be charged every September.

TUG’S Daycare & Preschool reserves the right to discharge a child if the staff and director agree that continued care of a particular child might be detrimental to the child or any part of the Daycare program.

A 2 week notice in writing is required for discontinuing service.

TUG’S is funded 100% by parent fees. It is important that you pay on time. We cannot extend credit to any family enrolled at TUG’S.

I have read this document and fully understand my obligation to pay my account.

Parent Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TUG’S Daycare & Preschool Director\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Permission and Emergency Authorization Releases**

**Child’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

By signing my name below, I agree to the following:

**Program** I agree to abide by the terms and conditions of Tug’s Daycare and Preschool Program. I have received and read a copy of the terms and conditions, and the Tug’s handbook. I agree that my child may use all the play equipment and participate in all the activities at Tug’s.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical** In case of an emergency involving the above named child, I authorized the Tug’s program to use the Mercy Medical Center-North Iowa for emergency medical treatment, if I or the child’s doctor could not be reached. I authorize Tug’s to call 911 to seek emergency care if deemed necessary, and agree that I would be responsible for the charges.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Fieldtrips** I give permission for the above named child to leave the center (Tug’s) for walks and to participate in field trips sponsored by Tug’s. Planned trips will be posted. Children will always be accompanied by Tug’s staff members, and transported in vehicles with car seats and adequate ratios met. No children will be allowed to be transported in the front seat of any vehicle.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Publicity** I give my consent to have picture taken of my child(ren) by the news media and or the staff at Tug’s. These may be used in newspapers, displays, bulletin boards or other educational publications.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My signature below shows that I agree to assume responsibility for any and all expenses that may be incurred under the circumstances outlined above:

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Return this form with $35 non-refundable registration fee to the Tug’s office.**

**IOWA SCHOOL-AGE CARE - HEALTH STATUS - PARENT STATEMENT**

**Parent/Guardian complete this page**

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:

**Child name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Body Health** - My child hasproblemswith

 Skin, hair, fingernails or toenails.

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

**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:

 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 nerv-ous habits (like twitches or tics)

 Females – difficult monthly periods Other special needs. Please describe:

 **Medication1** - My child takes medication.

Medication Name Time Given Reason for giving medication

 **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

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 Immuni-zation in the school office or in the school nurse’s office.

All other school-age child care programs must keep the Certifi-cate of Immunization on-site at the child care facility.

**Parent Signature:** **Date:**

**(required)**

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

2 July 2009

**IOWA SCHOOL-AGE CARE - HEALTH STATUS - PARENT STATEMENT**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Health Professional’s Physical Exam Findings** | **\*** | **Child Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |
|  |  |  |
|  |  | Birthdate: | Age: |  |
|  | **Date of Physical Exam**: |  |
|  | **Vaccines given Today**: |  |  |
|  |  |  |  |  |
|  | Height:\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  | Vaccines entered into IRIS database. | YesNo |  |
|  | Body Mass Index: \_\_\_\_\_\_\_\_\_\_, | DtaP/DTP/Td |  |  |
|  |  |  |  |  |
|  | There are weight concerns and | HEP B |  |  |
|  |  |  |  |  |
|  | Referral made to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | HIB |  |  |
|  |  |  |  |  |
|  | Blood Pressure: | Influenza |  |  |
|  |  |  |  |  |
|  | **Laboratory Screening:** | MMR |  |  |
|  | Blood Lead Level: \_\_\_\_\_\_\_\_ venous capillary (for child |  |  |
|  | Pneumococcal |  |  |
|  | under age 6 yr) |  |  |
|  |  |  |  |

Hgb. / Hct:

Urinalysis:

TB testing (high risk child only)

**Sensory Screening**

Vision: Right eye \_\_\_\_\_\_\_\_ Left eye \_\_\_\_\_\_\_\_\_

Hearing: Right ear \_\_\_\_\_\_\_\_ Left ear \_\_\_\_\_\_\_\_\_

Tympanometry: Right ear \_\_\_\_\_\_\_\_ Left ear \_\_\_\_\_\_\_\_\_

**Exam Results** *(N = normal limits) otherwise describe*

**Skin**:

**HEENT**:

**Teeth/Oral health**:

Date of Dentist Exam: \_\_\_\_\_\_\_\_\_\_ or None to date. Dental Referral Made Today Yes No

**Heart**:

**Lungs**:

**Stomach/Abdomen**:

**Genitalia**:

**Extremities, Joints, Muscles, Spine**:

**Neurological**:

**Other Notes**:

Polio

Varicella

Other

**Referrals made today**:

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

**Health provider authorizes the child to receive the following medications while at child care or school**

(Including *over-the-counter* and *prescribed*)

Medication Name Dosage

Fever/Pain reliever:

Sunscreen:

Cough medication:

Other - list all

**Health Provider Statement:**

The child may **fully participate** with ***NO*** health-related restrictions.

The child has the following **health-related restric-tions** to participation: (please specify)

\* Iowa Child Care regulations require an annual parent statement about the child’s health. Parents obtaining a physical exam are asked to have their family doctor or clinic use this form.

3

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Type (circle) MD DO PA ARNP

Address: May use stamp Telephone:

July 2009