Preschool : Mary J. Treglia Community House
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:
Name:	Phone #:	Relationship to child:
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: _____

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:

PARENTS/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:

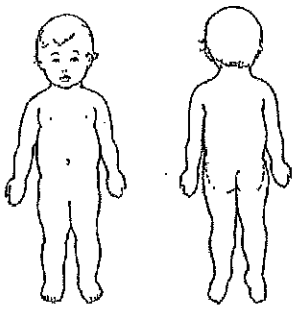
☐ **Allergies.** My child has allergies. (Medicine, food, dust, mold, pollen, insects, animals, etc.)

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 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

☐ 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:

Mary J. Treglia
COMMUNITY HOUSE
Educating, Empowering, and Advocating for Slouxland's Children & Families since 1921

Date of application: ____/____/____
(mm/dd/yyyy)

children must be 3-5 years old to attend Fee: $100/week full day; $80/week half day

Monday-Thursday

8:00 am-3:00 pm full day

8:00 am-12:15 pm half day

Does your child have a nickname they prefer? _____

Language(s) spoken at home: _____ Countries family is from: _____

Consent is given for the items initialed below:

_____ Motor Vehicle Trips and/or Field Trips
Type of vehicle: Bus
Child restraint system to be used: Seatbelt

_____ Sunscreen
Provided by the family.

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

_____ Decline Photo Release
Do not photograph my child while in the child care program.

I, _____ parent or guardian of the child named above, give my permission to the Mary J Treglia Community House Preschool to secure and authorize such emergency medical care, emergency dental care and treatment as my child might require while under the Center's supervision. I also authorize the Center 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.

For scholarship eligibility & data entry, please accurately fill out the following information:

Family's annual gross income _____

How many members are in the household? _____

I waive and release all rights and claims against Mary J. Treglia Community House and all of its agents for any accidents/injury my child may suffer in or around Mary J. Treglia Community House.

Signature: _____Date: ____/____/____

I certify that all the information given on this form is correct to the best of my knowledge. I promise to notify Mary J. Treglia Community House if any information changes.

Signature: _____Date: ____/____/____

- **You are responsible for supplying a copy of your child's physical examination report (updated within the past 12 months) and immunization record *before* your child may begin classes.**
- You are responsible for paying the $20 application fee to secure the preschool position of your child upon application.

OFFICE STAFF ONLY *Circle: Full day or half day?*	Yes or No?
Is the application completely filled out?	
Paid $20 application fee?	
PRESCHOOL STAFF ONLY BELOW Physical on child completed on:	Date
Immunization records given to center on:	
Date of Enrollment:	

(3/2021)

2021

Mary J. Treglia Community House

Confidentiality Agreement

In the course of participating in the classroom at Mary J. Treglia, you may have access to confidential child/family information. It is one of your most serious responsibilities not to reveal this information and use the information only as required.

By signing below, you acknowledge that you have read and fully understand all of the following:

- I understand that I may have indirect access to confidential individually identifiable child/family information in the course of participating in the classroom and I agree to protect the confidentiality of any individually identifiable child/family information to which I may have access during and after my participation.
- I shall adhere to all procedures that provide for minimizing the intentional and unintentional conveyance of individually identifiable information to unauthorized parties through written, electronic, or oral interactions.
- I understand that there may be state and federal laws and regulations that ensure the confidentiality of an individual's identifying child/family information and I agree to operate according to all applicable laws and regulations.

I have read, understand and agree to the provisions herein.

Parent/Guardian 1 Name

Parent/Guardian 1 Signature Date

Parent/Guardian 2 Name

Parent/Guardian 2 Signature Date

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 (start at age 24 months):_____

Head circumference (age 2 years and under):_____

Blood pressure (start at age 3 years):_____

Hgb or Hct (at 12 months):_____

Lead risk assessment:_____

Blood lead level: Date_____ Results_____

Sensory Screening

Vision assessment:_____

Vision acuity: Right eye_____ Left eye_____

Hearing assessment: Right ear_____ Left ear_____

Tympanometry (**may** attach results)

Developmental Screening

n = normal limits; otherwise describe

Developmental screening results:_____

Autism screening results:_____

Psychosocial/behavioral results:_____

Developmental 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:_____

Immunizations 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 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 ***with restrictions*** (see comments).

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

Signature:_____

May use stamp.

Check the provider credential type:
☐ MD ☐ DO ☐ PA ☐ ARNP

Address:_____

Telephone:_____

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

Recommendations for Preventive Pediatric Health Care – Infa

Bright Futures/American Academy of Pediat

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of chi health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances sugg children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to empl the need to avoid fragmentation of care. Refer to the specific guidance by age as listed in Bright Futures guidelines (Hagan JF, Shaw JS and Adolescents. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking

		INFANCY					
	AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo
HISTORY:	Initial/Interval	●	●	●	●	●	●
MEASUREMENTS:	Length/Height and Weight		●	●	●	●	●
	Head Circumference		●	●	●	●	●
	Weight for Length		●	●	●	●	●
	Body Mass Index[5]						
	Blood Pressure[6]		✱	✱	✱	✱	✱
SENSORY SCREENING:	Vision[7]		✱	✱	✱	✱	✱
	Hearing		●[8]	✱	✱	✱	✱
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT:							
	Developmental Screening[9]						
	Autism Screening[10]						
	Developmental Surveillance		●	●	●	●	●
	Psychosocial/Behavioral Assessment		●	●	●	●	●
	Alcohol and Drug Use Assessment[11]						
	Depression Screening[12]						
	PHYSICAL EXAMINATION[13]		●	●	●	●	●
PROCEDURES[14]:	Newborn Blood Screening[15]		←	●	→		
	Critical Congenital Heart Defect Screening[16]		●				
	Immunization[17]		●	●	●	●	●
	Hematocrit or Hemoglobin[18]						✱
	Lead Screening[19]						
	Tuberculosis Testing[21]				✱		
	Dyslipidemia Screening[22]						
	STI/HIV Screening[23]						
	Cervical Dysplasia Screening[24]						
	ORAL HEALTH[25]						
	Fluoride Varnish[26]						
	ANTICIPATORY GUIDANCE	●	●	●	●	●	●

KEY: ● = to be performed ● or ✱ = risk assessment to be performed with appropriate action to follow, if positive

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