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

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

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:	

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.** ☐ **Please help us find health or dental insurance.**
Other health care specialist name Type of specialty	Telephone #	

Child Name:

Infant, Toddler, Preschool Age – Child Health Form

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:

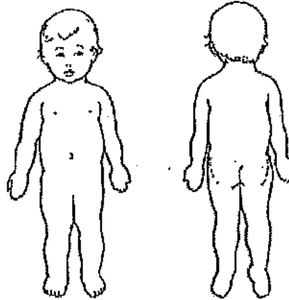
☐ **Allergies.** My child has allergies. (Medicine, food, dust, mold, pollen, insects, animals, etc.)

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 Preschool

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):	

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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

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

IDPH

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			

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

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Home Language Survey*

☐ Check here if the child's parents or legal guardians decline to provide information for this survey.

A. What language do family members use when speaking to the child in the home?

	1	2	3	4	5
	only English	mostly English but sometimes home language	both equally	mostly home language but some English	only home language (not English)

(write in home language: ____________________)

B. What language does the child use when speaking to family members in the home?

N/A	1	2	3	4	5
Not applicable	only English	mostly English but sometimes home language	both equally	mostly home language but some English	only home language (not English)

C. What language does the child use when speaking to other children in the classroom?

N/A	1	2	3	4	5
Not applicable	only English	mostly English but sometimes home language	both equally	mostly home language but some English	only home language (not English)

D. What language does the child use when speaking to the teachers?

N/A	1	2	3	4	5
Not applicable	only English	mostly English but sometimes home language	both equally	mostly home language but some English	only home language (not English)

Sum of circled numbers ________ / Number of questions answered ________ = ________

If this value is 2 or greater and the child is in a preschool 3, pre-K4, or kindergarten class, use Objectives 37 and 38.

*These research reports helped guide our thinking in the development of the "Home Language Survey":

Aikens, N. L., Caspe, M. S., Sprachman, S., López, M. L., & Atkins-Burnett, S. M. (June 2008). *Paper Symposium: Development of a language routing protocol for determining bilingual Spanish–English speaking children's language of assessment.* Biennial Head Start Research Conference. Washington, DC.

Puma, M., Bell, S., Cook, R., Heid, C., López, M. L., et al. (2005). *Head Start impact study: First year findings.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.

Gutiérrez-Clellen, V. F., & Kreiter, J. (2003). Understanding child bilingual acquisition using parent and teacher reports. *Applied Psycholinguistics, 24*(2), 267–88.

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