Tugs Daycare & Preschool
Registration/Release Forms

Child's Last Name _____First Name_____

Date of Birth_____Nickname_____

Address_____

Phone_____Gender_____Age_____

Father's Name_____Address_____

Phone_____Cell_____

Mother's Name_____Address_____

Phone_____Cell_____

Child lives with (circle one) Mother Father Both

Mother's Work

Employer_____

Work Phone_____

Father's Work

Employer_____

Work Phone_____

Child's Doctor_____ Address_____

Doctor's Phone_____Insurance Company_____

Child's Dentist_____Address_____

Dentist's Phone_____Insurance Company_____

Emergency Contacts:

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: (court ordered)

_____

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.

PARENTS COMPLETE THIS PAGE **Child's Name:** _____

Parents: 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 doctor 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.

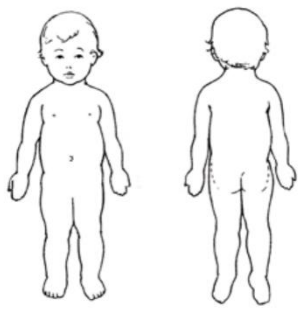
Development and Learning
☐ I am concerned about my child's behavior, development, or learning.
Please describe:

☐ **Medication** - My child takes medication.
List the name, time medication taken, and the reason medication prescribed.

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 aides 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, colic, spitting up
☐ Using toilet, toilet training, urinating
☐ Bones, muscles, movement, pain with moving
☐ Mobility, uses assistive equipment
☐ Nervous system, headaches, seizures, or nervous habits (like twitches)
☐ Needs special equipment. *Please describe*:

☐ **Allergies**-My child has allergies (medicine, food, dust, mold, pollen, insects, animals, etc.).
Please describe:

Parent questions or comments for the health care provider

Iowa Child Care Infant, Toddler, Preschool Age – Child Health Exam Form

HEALTH PROFESSIONAL COMPLETE THIS PAGE[1]

Child's Name: _____

Birthdate: **Age today:**

Date of Exam:_____

Height/Length:

Weight:

Head Circumference-for children age 2 yr and under:

Blood Pressure-start @ age 3 yr:

Hgb or Hct-anytime between 6-9 mo:

Blood Lead Level-start @ 12 mo:

Sensory Screening:

Vision: Right eye _____ Left eye _____

Hearing: Right ear _____ Left ear _____

Tympanometry (may attach results)

Developmental Screening[2]:

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

Oral Health/Dental Referral Made Today: ☐Yes ☐ No

Heart Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Space is available on back page for detailed comments or instructions pertaining to enrollment at child care or preschool.

[1] Iowa Child Care Regulations require an admission physical exam report within the previous year. Annually thereafter, a statement of health condition signed by an approved health care provider. The American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (RE9939, March 2000) www.aap.org

[2] Developmental screening procedures were expanded to include autism, developmental surveillance, and psychosocial/behavioral screening July 2009 by the Iowa EPSDT Medicaid program. Toll-free 800-383-3826.

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Immunization: May attach a copy of Iowa Department of Public Health Immunization Certificate

DtaP/DTP/Td	MMR
Hepatitis B	Pneumococcal
HIB	Varicella
Polio	Other
Influenza	

TB testing (only for high-risk child)

Medication: Health professional authorizes the child may receive the following medications while at child care or pre- school: (include *over-the-counter* and *prescribed*)

☐ Medication Name Dosage
☐ Cough medication
☐ Diaper crème:
☐ Fever or Pain reliever:
☐ Sunscreen:
Other

Other Medication should be listed with written instructions for use in child care.

Referrals made:

☐ Referred to ***hawk-i*** today 1-800-257-8563
Other: _____

Health Provider Assessment Statement:

☐ The child may participate in developmentally appropriate child care/preschool with ***NO*** health-related restrictions.

☐ The child may participate in developmentally appropriate child care/preschool ***with the following restrictions***:

May use stamp

Signature _____

Circle the Provider Credential Type: MD DO PA ARNP

Address: Telephone: