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 # Home email Work email

Child Name:

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 insurance? ☐ 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 **Type of specialty**	Telephone #	Specialist address:
Mental Health care specialist	Telephone #	Specialist address:

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.

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Parent/Guardian complete this page **Child name:** _____

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:

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:

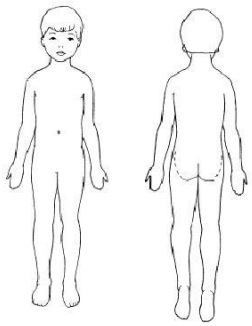
☐ **Allergy** - My child has allergies (list all allergies: food, medicine, fabric, inhalants, insects, animals, etc.):

Child has Epipen, inhaler, or other emergency medication.
☐ Yes ☐ No

Body Health - My child has problems with

☐ Skin, hair, fingernails or toenails.

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



☐ 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 nervous habits (like twitches or tics)
☐ Females – difficult monthly periods
☐ Other special needs. Please describe:

☐ **Medication**[1] - My child takes medication.
Medication Name Time Given Reason for giving medication

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: (required) **Date:**

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

IOWA SCHOOL-AGE CARE - HEALTH STATUS - PARENT STATEMENT

Health Professional's Physical Exam Findings *

Date of Physical Exam:

Height:_____ Weight: _____

Body Mass Index: _____,

☐ There are weight concerns and

☐ Referral made to _____

Blood Pressure:

Laboratory Screening:

Blood Lead Level: _____ ☐ venous ☐ capillary (for child 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:

Child Name: _____
Birthdate: Age:

Vaccines given Today:
Vaccines entered into IRIS database. ☐ Yes ☐ No

DtaP/DTP/Td

HEP B

HIB

Influenza

MMR

Pneumococcal

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)

Signature _____
Provider Type (circle) MD DO PA ARNP
Address: May use stamp Telephone:

* 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.