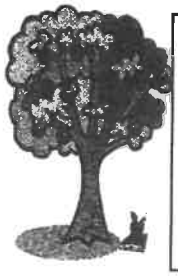

Apple Kids
600 10th Avenue
Marion, IA 52302

(319) 373-3808
AppleKidsMarionSite@gmail.com

Child's Name: _____

Start Date: _____

Classroom: _____

I /We have read and fully understand and have received copies of the following information provided by Apple Kids childcare and preschool:

1. General Policies and Procedures
2. Payment Policies and Procedures, Child Care Fee Information

I/ We have accurately completed & signed the following forms provided by Apple Kids. I/ We understand failure to complete the forms required prior to start date, and annually thereafter, may result in services suspended/revoked.

- ☐ Child's Medical/Allergy Alert Information *(Annually)*
- ☐ Pick Up Permission Form *(Annually)*
- ☐ Behavior Policy
- ☐ Intake Sheet
- ☐ Medical/Photo/Travel/School Transportation Authorizations *(Annually)*
- ☐ Physical- Dr. Signature/Date Required
  - *(Current within last year. Required prior to attending.)* (Annually)
- ☐ Immunzation Record- Dr. Signature/Date Required,
  - Must say Iowa Department of Public Health at the top. *(Current within last year. Required prior to attending.) (Annually)*
- ☐ Allergy Action Plan- Dr. Signature/Date Required. Parent/Guardian Signature required. (Annually) *(If Applicable)*

Contracted service times:

Arrival_____a.m. Departure_____p.m. Days Attending: _____

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Intake Sheet

I. Child's Identification Information

Full Name_____ Nickname_____

Address_____

Phone_____Sex__M / F__ Birthdate_____

II. Family Information: Parents or Guardians

Name Address Employer Work Phone

_____

_____

_____Single _____Married _____Divorced _____Separated _____Foster Parent

Names and ages of other children in the home:

_____ _____

_____ _____

III. Child's Medical History

-Allergies (goods, medications, bees, etc.)_____

- Birthmarks, skin conditions, etc. (please note where these are located on your child's body)

_____

-Chronic Illnesses or diseases (asthma, seizures, diabetes,

etc.)_____

(Please write "none" if your child has no medical problems)

Does your child take medications for this condition? _____Yes _____No

If yes, please state the name and dosage_____

Will the meds need to be given during program hours? _____Yes _____No

If yes, when and how is it given? _____

What should we do if your child has a problem related to his/her medical condition during program hours? _____

_____

_____

IV. Play and Sociability

-How does your child get along with other children? _____

_____

His/Her usual playmates are ____girls ____boys ____older ____younger

-What is the size of your child's usual play group?_____

-Previous group experience other than school ____preschool ____playgroup ____Sunday school ____other (specify)_____

V. Personality and Emotional Development

-Is your child affectionate? _____ To whom? _____

-Does your child accept new people easily? _____Yes _____No

-What are your child's fears? _____

-Is your child usually happy? _____Yes _____No

-What nervous habits does your child have? _____

VI. Discipline

-When you find it necessary to discipline your child, which parent usually does this and how?

_____

_____

_____

VII. Other Information:

-Favorite Snacks and Drinks _____

-Favorite Games _____

-Please give any further information that would be helpful in understanding your child or would enhance your child's experience in our program. _____

_____

_____

_____

Parental Emergency Medical Consent

PLEASE PRINT CLEARLY AND IN BLACK INK ONLY.

This form allows parents and guardians to authorize the provision of emergency treatment for the above name child who becomes ill or injured while under program authority when parents or guardians cannot be reached. *This form will be presented upon admission for treatment.*

Child's Full Name: _____ **Date of Birth:** _____

In the event reasonable attempts to contact me at _____ **(Parent Guardian/Phone Number)** or _____ **(Parent/Guardian Phone Number)** have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by Doctor **(Physician's Name)** _____ at **(Physician's Phone Number)** _____ or Doctor **(Dentist's Name)** _____ at **(Dentist's Phone Number)** _____. In the event that designated practitioners are not available, then by another licensed physician or dentist and the transfer of the child to **(Preferred Hospital)** _____. ***Emergency providers must be local****

1. Parents/Guardians/Custodians with whom the child resides:

Name: _____ Relationship to Child: _____
Address: _____ City: _____ State: _____
Cell Phone: _____ Alternate #_____
Employer: _____ E mail address: _____
Work Phone: _____ Work Hours: _____

Name: _____ Relationship to Child: _____
Address: _____ City: _____ State: _____
Cell Phone: _____ Alternate # _____
Employer: _____ E mail address: _____
Work Phone: _____ Work Hours: _____

2. Person to contact in case of emergency if parents are unavailable, and are authorized to pick up child:

Name: _____ Relationship to Child: _____
Address: _____ City: _____ State: _____
Cell Phone: _____ Alternate #_____
Employer: _____ E mail address: _____
Work Phone: _____ Work Hours: _____

Name: _____ Relationship to Child: _____
Address: _____ City: _____ State: _____
Cell Phone: _____ Alternate #_____
Employer: _____ E mail address: _____
Work Phone: _____ Work Hours: _____

3. Are there any custody or restraining orders for person(s) who may attempt to pick up or have contact with the child while in care at the center?

Name: _____ Name: _____

4. Information: *(All information must be completed, for all ages per DHS)*

Physicians Name: _____ **Dentist Name:** _____
Address: _____ **Address:** _____
City, State: _____ **City, State:** _____
Phone Number: _____ **Phone Number:** _____

_____ _____ _____ _____
Date of Last Tetanus | Insurance Company | Policy Holder's I.D. | Known Allergies:

_____
Present Medication (s)

_____ _____
Signature of Parent/ Guardian | Date | Signature of Parent/Guardian | Date

Pick Up Permission Form

Child's Full Name: _____

I hereby give permission for my child to leave the center with the following persons named below. It is the responsibility of the parents to notify the center in writing of any changes.

Name	Relationship
_____	Mother/Guardian
_____	Father/Guardian
_____	Emergency Contact
_____	_____
_____	_____
_____	_____
_____	_____

If there is a separation or divorce custody problem of which we should be aware, please explain: _____

_____

_____

Names of persons who may **NOT** pick up my child: _____

_____

Parent Signature: _____ Date: _____

APPLE KIDS BEHAVIOR POLICY

WHEN A CHILD IS HAVING A PROBLEM IN THE CLASSROOM:

1. Staff will try to redirect child from negative behavior

2. Child will be given verbal warnings

3. Child will be given time to regain control

4. The situation will be discussed with parents/guardians in an attempt to find possible cause of the behaviors

5. Child's disruptive behavior will be documented and maintained in confidentiality

WHEN THESE PROBLEMS BECOME UNCONTROLLABLE:

1. Parents may be called to pick up the child for the day

2. Parents will be called in for a conference to develop strategies for dealing with unwanted behavior and develop a plan of action

3. If behavior worsens or does not improve in a timely manner, another conference may be called to discuss seeking the advice and assistance from relevant external specialists to address the matter

CHILD'S ACTIONS FOR EXPULSION:

- Failure of child to adjust after a reasonable amount of time
- Uncontrollable tantrums/angry outbursts
- Ongoing physical abuse to staff or other children
- Swearing
- Behavior resulting in injury to staff or child
- Destruction of property
- Biting (not applicable for children under 3 years of age)

CHILD'S NAME_____

PARENT/GUARDIAN SIGNATURE_____

DATE_____

Travel and Activity Authorization

I give permission for my child, _____, to leave the center with supervision for field trips in a car or public transportation to special places, walks to the park, shopping trips, etc. I understand that a certified car seat, if required, or seat belts will be used on all car trips. No child under the age of 12 shall ride in the front seat.

Restrictions: _____

Parent Signature: _____ Date: _____

Medical Bills

I understand that I, _____ (parent's name) am responsible for all medical bills for my child _____ (child's name).

Parent Signature: _____ Date: _____

Water Activities

I hereby give my child, _____ permission to participate in water activities at Apple Kids.

Parent Signature: _____ Date: _____

School Transporation

A staff member of Apple Kids is hereby authorized to drop off and pick up my child, _____, to and from his/her school, _____, each day. This will be done in a center owned vehicle using only 1 staff member.

Parent Signature: _____ Date: _____

Photography/ Videotaping Release

Apple Kids has a web monitoring system and I/ We give consent that Apple Kids may take photographs/ videos of our child (name of child) _____. I/ We will be notified if the program would like to use the photographs/ videotapes of our child in promoting the center. If I/ we authorize this, no financial benefits from the use of the photographs are obligated to be paid to our family.

Restrictions: _____

Parent Signature: _____ Date: _____

CHILD CARE PHYSICAL EXAMINATION

Child's Full Name _____ **Date of Exam** _____

Age _____ **Height** _____ Weight _____ **BP** _____ P _____

Vision: Eye Correction required ☐ Yes ☐ No ☐ Glasses ☐ Contact Lens

Hearing: ☐ Normal ☐ Abnormal ☐ Not Tested

EENT _____
Teeth _____
Neck _____
Chest _____
Lungs _____

Heart _____
Abd _____
Hernia _____
Extremities/Skin _____
Posture/Spine _____

Genitalia _____
Rectum, Anus _____
Neuromuscular _____
Urinalysis _____

If needed:

Hemoglobin or Hematocrit _____
Sickle Cell screening _____
Lead screening _____

Tuberculin screening _____
Development testing _____
Other _____

The child is under the care of a physician for the following medical condition(s):

_____

_____

Known allergies: _____

Additional health information: _____

_____

_____

The child is _____ is not _____ physically and/or emotionally able to participate in your program.

_____
Signature of Physician or Designee

_____
Date

PARENT: Please complete the following:

Diseases the child has had _____

_____

Any special health needs _____

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			
Varicella Chicken Pox if applicant has a history of natural disease write "Immune to Varicella"			
Pneumococcal *PCV/PPV*			

	Vaccine	Date Given	Doctor / Clinic / Source
Meningococcal *MCV4/MPSV4*			
Hepatitis A			
Rotavirus			
Human Papilloma Virus *HPV*			
Other			

Licensed Child Care Requirements

4 through 5 months
1 dose Diphtheria/Tetanus/Pertussis
1 dose Polio
1 dose Hib
1 dose Pneumococcal

6 through 11 months
2 doses Diphtheria/Tetanus/Pertussis
2 doses Polio
2 doses Hib
2 doses Pneumococcal

12 months through 18 months
3 doses Diphtheria/Tetanus/Pertussis
2 doses Polio
2 doses Hib or 1 dose received at ≥ 15 months of age
3 doses Pneumococcal if received 1 or 2 doses < 12 months of age, or 2 doses if received 1 dose ≥ 12 months of age or has not received this vaccine before.

19 through 23 months
4 doses Diphtheria/Tetanus/Pertussis
3 doses Polio
3 doses Hib with the final dose in the series ≥ 12 months of age or 1 dose received ≥ 15 months of age
1 dose Measles/Rubella ≥ 12 months of age
1 dose Varicella ≥ 12 months of age if born on or after September 15, 1997, or a reliable history of natural disease
1 dose of Pneumococcal if 3 doses if received 1 or 2 doses < 12 months of age or 2 doses if received 1 dose ≥ 12 months of age or has not received this vaccine before

24 months and older
For requirements in the 19-23 months, except 4 doses Pneumococcal if received 3 doses < 12 months of age, or 3 doses if received 2 doses < 12 months of age, or 2 doses if received 1 dose < 12 months of age or received 1 dose between 12 and 23 months of age or 1 dose if no doses have been received prior to 24 months of age.

Elementary/Secondary School Requirements

4 years of age and older
5 doses Diphtheria/Tetanus/Pertussis with at least 1 dose received ≥ 4 years of age if born on or after September 15, 2005; or 4 doses, with 1 dose received ≥ 4 years of age if born on or before September 15, 2000, but before September 15, 2003; or 3 doses, with 1 dose received ≥ 4 years of age if born on or before September 15, 2000.
4 doses Polio with 1 dose received ≥ 4 years of age if born on or after September 15, 2000; or 3 doses, with 1 dose received ≥ 4 years of age if born on or before September 15, 2000.
2 doses Measles/Rubella the first dose the I have been received ≥ 12 months of age; the second dose shall have been received ≥ 28 days after the first
3 doses Hepatitis B if born on or after July 1, 1994
2 doses Varicella ≥ 12 months of age if born on or after September 15, 2003; or 1 dose received ≥ 12 months of age if born on or after September 15, 1997 but before September 15, 2003, unless the age is unknown or a reliable history of natural disease.

Rev. 12/2008