Grace Lutheran Preschool

415 10th Street, DeWitt, IA 52742 - 563.659.9193

Enrollment Form

Student Information:

Child's Name:_____

(Last) (First) (Preferred)

Other children or people living in the home (name, age & relationship):

_____

_____

Health Information:

Medical Conditions (List all medical conditions, diseases, hospitalizations, chronic physical problems for your child, such as premature birth, developmental delays, stuttering…):

_____

_____

Are you aware of any vision, speech or hearing difficulties with your child? If yes, please explain. _____

Date of: Last Dental Visit _____

Have you visited an eye doctor? _____

Does your child wear glasses? _____

Has your child had a hearing test? _____ Results: _____

Is your child right-handed or left-handed? _____

PARENTAL EMERGENCY MEDICAL CONSENT

This form must be presented upon admission for treatment

This form allows parents and guardians to authorize the provision of emergency treatment for below named child who becomes ill or injured while under program authority when parents or guardians cannot be reached.

In the event reasonable attempts to contact have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by the doctor or dentist listed below, or if unavailable, another licensed physician or dentist.

I agree to pay all costs and fees as secured or authorized under this consent.

CHILD'S NAME:		**BIRTH DATE:**
PARENT(S)/GUARDIAN(S) WITH WHOM THE CHILD RESIDES		
1. NAME	RELATIONSHIP TO CHILD	
ADDRESS	EMPLOYER	
HOME NUMBER	CELL NUMBER	WORK NUMBER
2. NAME	RELATIONSHIP TO CHILD	
ADDRESS	EMPLOYER	
HOME NUMBER	CELL NUMBER	WORK NUMBER
EMERGENCY CONTACT PERSON(S)		
1. NAME	RELATIONSHIP TO CHILD	
HOME NUMBER	CELL NUMBER	WORK NUMBER
2. NAME	RELATIONSHIP TO CHILD	
HOME NUMBER	CELL NUMBER	WORK NUMBER
3. NAME	RELATIONSHIP TO CHILD	
HOME NUMBER	CELL NUMBER	WORK NUMBER

PERSONS AUTHORIZED TO PICK UP CHILD	**ADDRESS**	**PHONE NUMBER**
1.		
2.		
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**

PHYSICIAN NAME	**DENTIST NAME**
PHONE NUMBER	PHONE NUMBER
ADDRESS	ADDRESS
HOSPITAL PREFERENCE	
KNOWN ALLERGIES	DATE OF LAST TETANUS
PRESENT MEDICATION	
INSURANCE COMPANY	POLICY HOLDER ID

This consent will be in effect for one year beginning (date) _____

_____

SIGNATURE OF PARENT OR GUARDIAN **DATE**

_____

SIGNATURE OF PARENT OR GUARDIAN **DATE**

STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Infant, Toddler, Preschool Age (including Kindergarten entry)
Child Health Form

HEALTH PROFESSIONAL COMPLETE PAGE

OR PROVIDE COPY OF WELL CHILD PHYSICAL (ANNUALLY)

Date of Exam: _____

Height/Length: _____ Weight: _____

BMI – starting at age 24 mo.: _____

Head Circumference @ age 2 yr. and under: _____

Blood Pressure-start @ age 3 yr.: _____

Hgb or Hct @ 12 mo.: _____

Lead Risk Assessment: _____

Blood Lead Level @ 1 yr. & 2 yr.: date_____ results_____

Sensory Screening:

Vison Assessment: _____

Vision Acuity: Right eye _____ Left eye _____

Hearing Assessment: Right ear _____ Left ear _____

Tympanometry (may attach results)

Developmental Screening/Surveillance:
(n = normal limits) otherwise describe

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 Date of Dental exam _____

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

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Child Name: _____

Date of Birth: _____ **Age:** _____

Immunization and TB Testing: (check as indicated)

☐ IDPH Certificate of Immunization reviewed and signed

☐ TB testing completed (only for high-risk child)

Health provider authorizes the child may receive the following at child care: (include *over-the-counter medications)*

	Name	Dosage
☐ Diaper cream/ointment:		
☐ Fever or Pain reliever:		
☐ Sunscreen:		
☐ Other		

Prescribed Medication should be listed with written instructions for use in child care. Medication forms available at https://hhs.iowa.gov/hcci/products

Additional Referrals made:

☐ _____

☐ _____

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 restrictions*** (see comments).

☐ The child has a special needs care plan
Type of plan _____
(Please complete and give to parent for child care templates at https://hhs.iowa.gov/hcci/products)

Comments:

May use stamp

Signature _____

Circle Provider Type: MD DO PA ARNP Chiropractor

Address: Telephone:

American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures July 2022) https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.153767288.1525543973.1674849857-346854326.1661880588

IOWA | Health and Human Services

Certificate of Immunization

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____

Parent/Guardian: _____ Address: _____ Phone: (_____)_____

A representative of the local Board of Health or Iowa Department of Health and Human Services may review this certificate for audit purposes.

Vaccine	Vaccine Type	Date Given	Source
Diphtheria, Tetanus, Pertussis DTaP/DTP/ DT/Td/Tdap			
Polio IPV/OPV			
Measles, Rubella MMR			
Haemophilus influenzae type b Hib			

Vaccine	Vaccine Type	Date Given	Source
Hepatitis B Hep B			
Varicella* Chickenpox			
Pneumococcal PCV			
Meningococcal MenACWY			

* If patient has a history of natural disease, write “Immune to Varicella”.

I certify the above named applicant has a record of age-appropriate immunizations that meet the requirement for licensed child care or school enrollment.

Name (Print): _____
Physician (MD, DO), Physician Assistant, Nurse, or Certified Medical Assistant

Signature: _____ Date: _____
Physician (MD, DO), Physician Assistant, Nurse, or Certified Medical Assistant

July 2024

Grace Lutheran Preschool

415 10th St., DeWitt, IA 52742
(563) 659-9153

TRAVEL AND ACTIVITY AUTHORIZATION

I give permission for my child, _____, to leave the above-named facility for walking trips to the bowling alley, city park and other locations. I will be notified in advance of the above trips. I understand that the preschool may take walks around the neighborhood without prior notification to enhance learning experiences.

Restrictions on such trips:(Additional restrictions, if any, set by parent/guardian)

1.
2.
3.

PICTURE RELEASE

☐ I hereby give my consent to let my child be photographed for use by the center in newspapers, preschool/congregation website, congregation and school bulletin boards or other media for the purpose of publicity or advertisements.

☐ I do not give my consent to let my child be photographed.

_____ _____
Signature or Parent/Guardian Date

BUSING (4's Only)

_____ If your child will be riding the bus after school (4s only), please initial on this line giving permission for us to place your child on the bus to go home. Once the child is on the bus; they are the responsibility of the Central DeWitt Community School District.