

School _____

**North Scott
Child Care**

PARENTAL EMERGENCY MEDICAL CONSENT
This form must be presented upon admission for treatment.

Child's Full Name _____

Date of Birth _____

This form allows parents and guardians to authorize the provision of emergency treatment for above 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 me at _____ (phone number) or _____ (phone number) have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by Doctor _____ (physician) at _____ (phone number) or Doctor _____ (dentist) at _____ or in the event the designated practitioners are not available, then by another licensed physician or dentist; and the transfer of the child to _____ (preferred hospital).

1. Parents/Guardians/Custodians with Whom the Child Resides:

• Name _____	Relationship to Child _____
Address _____	Home Phone _____ Cell Phone _____
Employer _____	Department _____
Work Phone _____	Work Hours _____

• Name _____	Relationship to Child _____
Address _____	Home Phone _____ Cell Phone _____
Employer _____	Department _____
Work Phone _____	Work Hours _____

2. Persons to Contact In Case of Emergency if Parents Are Unavailable, and are Authorized to Pick Up Child:

• Name _____	Relationship to Child _____
Address _____	Home Phone _____ Cell Phone _____
Employer _____	Department _____
Work Phone _____	Work Hours _____

• Name _____	Relationship to Child _____
Address _____	Home Phone _____ Cell Phone _____
Employer _____	Department _____
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:

Physician name _____	Dentist name _____
Street address _____	Street address _____
City, State _____	City, State _____
Phone # _____	Phone # _____

Date of Last Tetanus _____	Known Allergies _____
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Present Medication _____

Insurance Company _____	Policy Holder's I.D. _____
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This consent will be in effect for one year beginning (date) _____

Signature Parent/Guardian _____	Date _____	Signature Parent/Guardian _____	Date _____
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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. If the person is not a Parent/Guardian that picks up my child on a daily basis, I will notify the center whom to expect.

<u>NAME</u>	<u>PHONE</u>	<u>RELATIONSHIP</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

TRANSPORTATION AND ACTIVITY AUTHORIZATION

I do / do not (circle one) give authorization for North Scott Child Care Center to transport my child _____ to leave the child care in a car or bus, to/from school, special places, walks, field trips, or in the event of an emergency. Each child will be secured in a seat belt for any field trip/activity, other than on a school bus or in the event of an emergency. I understand that I will be notified before each such field trip/activity.

PICTURE RELEASE

I hereby do / do not (circle one) give my consent to let my child be photographed for use by the center in newspapers or other media, for the purpose of publicity or advertisement.

I give permission for my child to be cared for at North Scott Child Care Center.

Name: _____

Birth date: _____

Ethnic/Racial Identity of Child (Indicate by a check) Answering this question is voluntary					
White	Hispanic or Latino	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander

My infant/child's usual times of attendance will be:

Days: Monday Tuesday Wednesday Thursday Friday Saturday Sunday
 Hours: Arriving at _____ Leaving at _____
 Arriving at _____ Leaving at _____

My infant/child's anticipated meal participation will be:

☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack

*This consent will be in effect for one year beginning (date) _____. It is the responsibility of the Parents/Guardians to notify the center, in writing, of any changes.

Signature of Parent/Guardian

Date

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:

Vision 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

PARENT/GUARDIAN (COMPLETE THIS PAGE ANNUALLY) **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:

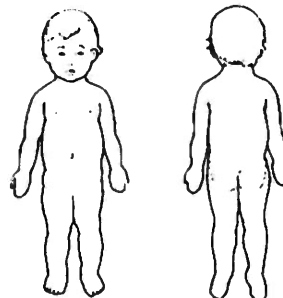
☐ **Allergies** - My child has allergies. (Medicine, food, dust, mold, pollen, insects, animals, etc.).

Please describe:

☐ **Special Needs Care Plan** - My child has a special need and needs a care plan for child care. Please discuss with your health care provider.

☐ **Body Health** - My child has skin problems, birthmarks, Mongolian spots, etc.

Map and describe color/shape of skin markings
birthmarks, scars, moles



- ☐ Eyes \ vision, glasses
- ☐ Ears \ hearing, hearing aids or device, ear-aches, tubes in ears
- ☐ Nose problems, nosebleeds, runny nose
- ☐ Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring
- ☐ Nervous System, headaches, seizures
- ☐ 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.
- ☐ Needs special equipment.

List equipment:

☐ **Medication¹** - My child takes medication.

<u>Medication Name</u>	<u>Time Given</u>	<u>Reason for Medication</u>

☐ **Child has Emergency Medication** - Epipen, Respiratory Inhaler, Nebulizer, etc. (Please complete care/action plan) templates at <https://hhs.iowa.gov/hcci/products>

Parent/Guardian questions or comments for the health care provider:

Parent/Guardian Signature (required) _____ Date: _____

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