PreKindergarten Information

Child's Full Name _____

Name child is to be called at school _____
(This is the name your child will be taught to write also.)

Birth Date _____

Parents' Names _____

Address _____

Phone _____
Mom's Cell phone _____ Dad's Cell phone _____

E-mail _____

Brothers & Sisters and Ages

_____

_____

_____

What would you like your child to gain from from his/her PreKindergarten experience?

_____

_____

_____

_____

Does your child have any fears? If so, please explain.

_____

_____

_____

What other information would be helpful to us in understanding your child?

_____

_____

Over →

Gender: male female (circle one)

Race (circle one or more):
American Indian or Alaskan Native
Asian
Black or African American
Hispanic, Latino, or Spanish orgin
Native Hawaiian or Other Pacific Islander
White
Other: _____

Religion: (circle one)
Catholic Non-Catholic

This information is strictly for demographic statistics required by the state and will not be shared.

Infant, Toddler, Preschool Age – Child Health Form

HEALTH PROFESSIONAL COMPLETE THIS PAGE

Child's Name: _____

Birthdate: _____ **Age today:** _____

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: 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

Health Care Provider comments:

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Immunization: Please attach:

☐ Iowa Department of Public Health
Certificate of Immunization

☐ Iowa Department of Public Health
Certificate of Immunization Exemption Medical

☐ Iowa Department of Public Health
Certificate of Immunization Exemption Religious.

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

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

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

Other Medication should be listed with written instructions for use in child care. Medication forms available at www.idph.iowa.gov/hcci/products

Referrals made:

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

☐ Other: _____

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 attach)

May use stamp

Signature _____
Circle the Provider Credential Type: MD DO PA ARNP
Address Telephone

[1] Iowa Child Care Regulations require an admission physical exam report within the previous year and annually.
The American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures 2015)
https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

WCC YES ___ No ___

Iowa Department of Public Health - Bureau of Immunization
Certificate of Immunization

104 BROADWAY PLACE
ANAMOSA, IA 52205
(319) 462-6135 EXT. 6223

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

Parent/Guardian: _____ Address: _____ Phone: _____

Medical Waiver

A waiver to _____ vaccine(s) due to a medical contraindication is granted to the applicant.
(list the vaccine(s) to be waived)

_____ _____
Signature of Doctor Date

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

_____ _____
Signature of Doctor or Health Official Date

Immunizations

Vaccine	Date Given	Doctor / Clinic / Source	Clinic Location
DTaP/DTP DT/Td *Diphtheria, Tetanus Pertussis*			
Polio *Poliomyelitis*			
MMR *Measles, Mumps, Rubella*			
Hib *Haemophilus Influenzae Type b*			
Hepatitis B			
Varicella			
Pneumococcal *PCV* *PPV*			

A representative of the local Board of Health or Iowa Department of Public Health may review this certificate for survey purposes.

Requirements for School Entry

Diphtheria-Tetanus-Pertussis (DTP or DTaP)
3 doses required, at least one dose on or after age 4

Polio
3 doses required, at least one dose on or after age 4

Measles-Rubella
2 doses required if enrolled after July 3, 1991,
1 dose required if enrolled before July 3, 1991

Hepatitis B
3 doses required if born on or after July 1, 1994

Requirements for Day Care

Diphtheria-Tetanus-Pertussis (DTP or DTaP)
1 dose for 2-18 months of age,
3 doses at 18 months of age and older

Polio
1 dose for 2-18 months of age
3 doses at 18 months of age and older

Measles-Rubella
1 dose on or after 12 months of age

Haemophilus Influenzae Type b (Hib)
1 dose for 2-18 months of age,
3 doses at 18 months of age and older or
1 dose after 15 months of age

IMMUNIZATION REQUIREMENTS

Applicants enrolled or attempting to enroll shall have received the following vaccines in accordance with the doses and age requirements listed below. If, at any time, the age of the child is between the listed ages, the child must have received the number of doses in the "Total Doses Required" column.

Institution	Age	Vaccine	Total Doses Required
Licensed Child Care Center	Less than 4 months of age	This is not a recommended administration schedule, but contains the minimum requirements for participation in licensed child care. Routine vaccination begins at 2 months of age.	
	4 months through 5 months of age	Diphtheria/Tetanus/Pertussis	1 dose
		Polio	1 dose
		Haemophilus influenzae type B	1 dose
		Pneumococcal	1 dose
	6 months through 11 months of age	Diphtheria/Tetanus/Pertussis	2 doses
		Polio	2 doses
		Haemophilus influenzae type B	2 doses
		Pneumococcal	2 doses
	12 months through 18 months of age	Diphtheria/Tetanus/Pertussis	3 doses
		Polio	2 doses
		Haemophilus influenzae type B	2 doses, or 1 dose received when the applicant is 15 months of age or older.
		Pneumococcal	3 doses if the applicant received 1 or 2 doses before 12 months of age, or 2 doses if the applicant has not received any previous doses or has received 1 dose on or after 12 months of age.
	19 months through 23 months of age	Diphtheria/Tetanus/Pertussis	4 doses
		Polio	3 doses
		Haemophilus influenzae type B	3 doses, with the final dose in the series received on or after 12 months of age, or 1 dose received when the applicant is 15 months of age or older.
		Pneumococcal	4 doses, or 3 doses if the applicant received 1 or 2 doses before 12 months of age, or 2 doses if the applicant has not received any previous doses or has received 1 dose on or after 12 months of age.
		Measles/Rubella	1 dose of measles/rubella-containing vaccine received on or after 12 months of age, or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Varicella	1 dose received on or after 12 months of age if the applicant was born on or after September 16, 1997, unless the applicant has had a reliable history of natural disease.
	24 months and older	Diphtheria/Tetanus/Pertussis	4 doses
		Polio	3 doses
		Haemophilus influenzae type B	3 doses, with the final dose in the series received on or after 12 months of age, or 1 dose received when the applicant is 15 months of age or older. Hib vaccine is not indicated for persons 60 months of age or older.
		Pneumococcal	4 doses if the applicant received 3 doses before 12 months of age, or 3 doses if the applicant received 2 doses before 12 months of age, or 2 doses if the applicant received 1 dose before 12 months of age or received 1 dose between 12 and 23 months of age, or 1 dose if no doses had been received prior to 24 months of age. Pneumococcal vaccine is not indicated for persons 60 months of age or older.
		Measles/Rubella	1 dose of measles/rubella-containing vaccine received on or after 12 months of age, or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Varicella	1 dose received on or after 12 months of age if the applicant was born on or after September 16, 1997, unless the applicant has had a reliable history of natural disease.
Elementary or Secondary School (K-12)	4 years of age and older	Diphtheria/Tetanus/ Pertussis[3,4]	3 doses, with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born on or before September 15, 2000, or 4 doses, with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born after September 15, 2000, but before September 15, 2003, or 5 doses with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born on or after September 15, 2003.[2] DTaP is not indicated for persons 7 years of age and older, therefore, a tetanus-and diphtheria-containing vaccine should be used.
		Polio[5]	3 doses, with at least 1 dose received on or after 4 years of age if the applicant was born on or before September 15, 2003, or 4 doses, with at least 1 dose received on or after 4 years of age if the applicant was born after September 15, 2003.[5]
		Measles/Rubella[1]	2 doses of measles/rubella-containing vaccine, the first dose shall have been received on or after 12 months of age, the second dose shall have been received no less than 28 days after the first dose, or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Hepatitis B	3 doses if the applicant was born on or after July 1, 1994.
		Varicella	1 dose received on or after 12 months of age if the applicant was born on or after September 16, 1997, but born before September 16, 2003, unless the applicant has had a reliable history of natural disease; or 2 doses received on or after 12 months of age if the applicant was born on or after September 16, 2003, unless the applicant has a reliable history of natural disease.[7]

[1] Mumps vaccine may be included in measles/rubella-containing vaccine.
[2] The 5th dose of DTaP is not necessary if the 4th dose was administered on or after 4 years of age.
[3] Applicants 7 through 18 years of age who received their 1st dose of diphtheria/tetanus/pertussis-containing vaccine before 12 months of age should receive a total of 4 doses, with one of those doses administered on or after 4 years of age.
[4] Applicants 7 through 18 years of age who received their 1st dose of diphtheria/tetanus/pertussis-containing vaccine at 12 months of age or older should receive a total of 3 doses, with one of those doses administered on or after 4 years of age.
[5] If an applicant received an inactivated poliovirus (IPV) or wild-oral poliovirus (OPV) series, a 4th dose is not necessary if the 3rd dose was administered on or after 4 years of age.
[6] If both OPV and IPV were administered as part of the series, a total of 4 doses are required, regardless of the applicant's current age.
[7] Administer 2 doses of varicella vaccine at least 3 months apart. If applicant is less than 13 years of age, the minimum interval between the 1st dose and 2nd dose is a minimum of 28 days or greater than the 1st dose. Administer 2 doses of varicella vaccine to applicants 13 years of age or older at least 4 weeks apart. The minimum interval between the 1st and 2nd dose of varicella for an applicant 13 years of age or older is 28 days.

Rev. 1-10

Pick-Up Permission Form

Child's Name _____

This form is to tell us who is able to pick up your child from school. If at any time, you would like to have someone not listed here pick up your child, please either call and let us know or put a note in your child's folder. Thanks!

The person who will usually pick up my child is _____
This person's relationship to child _____
This person's phone number _____

If this person does not come to pick up your child, whom should we call? Please list name and phone number _____

If your child becomes sick to needs to be picked up early from school, whom should we call? Name and phone number _____

Mom's place of employment and phone number _____
_____

Dad's place of employment and phone number _____
_____

The following people have my permission to pick up my child at school:

Person	Relationship to child	Phone Number

Is there anyone who is not able to pick up your child? If so, please list here:

_____

_____

Parent's Signature _____

Date _____