Child Enrollment Information

Child Information			
Child's Name:		**Date of Birth:**	
Address:	**City:**	**State:**	**ZIP:**
Allergies, special instructions, comforting items:			

Parent/Guardian Information (1)			
Name:		**Relationship to child:**	
Address: (if different than child)	**City:**	**State:**	**ZIP:**
Home #:	**Cell #:**	**Work #:**	
Email (personal):		**Email (work):**	
Place of work:		**Address:**	

Parent/Guardian Information (2)			
Name:		**Relationship to child:**	
Address: (if different than child)	**City:**	**State:**	**ZIP:**
Home #:	**Cell #:**	**Work #:**	
Email (personal):		**Email (work):**	
Place of work:		**Address:**	

Emergency Contact (1)			
Name:		**Relationship to child:**	
Address:	**City:**	**State:**	
Home #:	**Cell #:**	**Work #:**	
Email (personal):		**Email (work):**	

Emergency Contact (2)			
Name:		**Relationship to child:**	
Address:	**City:**	**State:**	
Home #:	**Cell #:**	**Work #:**	
Email (personal):		**Email (work):**	

Emergency Contact (3) – Out-of-Area/Out-of-State			
Name:		**Relationship to child:**	
Address:	**City:**	**State:**	
Home #:	**Cell #:**	**Work #:**	
Email (personal):		**Email (work):**	

Medical Information		
Child's Doctor's Name:		**Phone #:**
Address:	**City:**	**State:**
Preferred Hospital to Contact:		**Phone #:**
Address:	**City:**	**State:**

Child's Dentist's Name:		**Phone #:**
Address:	**City:**	**State:**

Does your child have any special needs that I need to be aware of? _____

_____

_____

Persons allowed to pick up my child if I am unable to: (Also list emergency contacts below if you want to allow them to pick up your child)		
Name:	**Phone #:**	**Relationship to child:**
Name:	**Phone #:**	**Relationship to child:**
Name:	**Phone #:**	**Relationship to child:**
Name:	**Phone #:**	**Relationship to child:**
Name:	**Phone #:**	**Relationship to child:**
Name:	**Phone #:**	**Relationship to child:**

Any one NOT allowed to pick up my child (with copy of court order, if applicable):

Parent's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

Consent & Release

Name of Facility: _____ Address of Facility: _____

Name of Child: _____

The following persons are allowed to pick up my child from child care in the event that I am unable to:

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Anyone **NOT** permitted to pick up my child (with copy of court order, if applicable):

_____	_____	_____
_____	_____	_____

Consent is given for the items initialed below:

_____ Walking Trips

To the following: _____

_____ Motor Vehicle Trips

Type of vehicle: _____ To the following: _____

Child restraint system to be used: _____

Special needs of child during transport: _____

_____ Daily Transportation

Type of vehicle: _____ To/from the following: _____

Child restraint system to be used: _____

Special needs of child during transport: _____

_____ Swimming and/or Wading

Location: _____

_____ Other Activities (e.g. homework supervision, trips to neighborhood playgrounds, special trips)

Description: _____

_____ Photo Release

My child may be photographed while in child care. Photos may be used in newspapers or other media for the purpose of publicity or shared with other families whose children attend the child care program.

_____ Decline Photo Release

Do not photograph my child while in the child care program.

_____ _____

Signature of Parent Date

Emergency Medical Treatment Authorization

Permission for medical care in parental absence.

Child's Full Name _____ Birth Date _____

Name child answers to: _____

I, _____ parent or guardian of the child named above give my permission to _____, child care home provider, to secure and authorize such emergency medical care and treatment as my child might require while under the Provider's supervision. I also authorize the Provider to administer emergency care or treatment as required, until emergency medical assistance arrives. I also agree to pay all the costs and fees contingent on any emergency medical care and treatment for my child as secured or authorized under this consent.

NOTE: Every effort will be made to notify parents <u>immediately</u> in case of emergency. In the event of an emergency, it would be necessary to have the following information:

Name of Parent or Legal Guardian: _____
Address: _____
Home Phone: _____ Work Phone: _____

Name of Parent or Legal Guardian: _____
Address: _____
Home Phone: _____ Work Phone: _____

Doctor: _____
Doctor's Address: _____
Doctor's Phone: _____

Preferred Hospital to Contact: _____
Address: _____ Phone: _____

Persons to be contacted in emergency if the parents are unavailable:

Name	Home Phone	Work Phone	Relationship

Present medication(s): _____
Known allergies: _____
Date of last tetanus: _____ Religious Preference: _____
Insurance: _____

Father's signature: _____ Date: _____

Mother's signature: _____ Date: _____

School-Age Child Health Form/Parent Statement of Health

HEALTH PROFESSIONAL COMPLETE PAGE –
OR PROVIDE COPY OF WELL CHILD PHYSICAL

Date of Exam: _____

Height: _____ Weight: _____

Body Mass Index: _____,

☐There are weight concerns

☐Referral made to _____

Blood Pressure: _____

Laboratory Screening:

Blood Lead Level: Date_____ ☐ venous ☐ capillary (for child under age 6 yr.) Results _____

Hgb. / Hct: _____

Urinalysis: _____

Sensory Screening

Vision Acuity: 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:

Psychosocial/Behavioral Assessment (Depression screening starting at age 11)

Allergies:

Environmental
Medication
Food
Insects
Other

American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures March 2021) https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

Child Name: _____

Date of Birth: _____ Age: _____

Immunization and TB Testing: (check as indicated)

☐ IDPH Certificate of Immunization reviewed/signed

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

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

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

Additional Referrals made:

☐ _____

☐ _____

Health Provider Statement:

☐The child may **fully participate** with ***NO*** health-related restrictions.

☐The child has the following **health-related restrictions** to participation: (please specify)

☐ The child has a special needs care plan
Type of plan _____
(Please complete and give to parent for child care)

Health Care Provider Comments:

May use stamp

Signature _____

Circle the Provider Type: **MD DO PA ARNP**

Address: Telephone:

School-Age Child Health Form/Parent Statement of Health

Parent/Guardian complete this page

Child name: _____

Please use an **X** in the box ☐ for 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. Please describe:

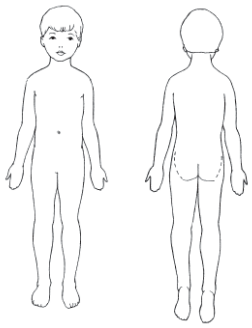
School and Learning - My child
☐ Is doing well at school.
☐ Is having difficulty in some classes.
☐ Does not want to go to school.
☐ Frequently misses or is late for school.
☐ I am concerned about how my child is doing in school. Please describe:

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

☐ **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 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
☐ 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

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

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

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

Recommendations for Preventive Pediatric Health Care – School-Age Child

Bright Futures/American Academy of Pediatrics

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care. Refer to the specific guidance by age as listed in Bright Futures guidelines (Hagan JF, Shaw JS, Duncan PM, eds. Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

	MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY: Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS: Length/Height and Weight	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference																	
Weight for Length																	
Body Mass Index[5]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING: Vision[7]	●	●	✱	●	✱	●	✱	●	✱	✱	●	✱	✱	✱	✱	✱	✱
Hearing	●	●	✱	●	✱	●	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT:																	
Developmental Screening[9]																	
Autism Screening[10]																	
Developmental Surveillance	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol and Drug Use Assessment[11]							✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱
Depression Screening[12]							●	●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[13]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[14]**:** Newborn Blood Screening[15]																	
Critical Congenital Heart Defect Screening[16]																	
Immunization[17]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin[18]	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱
Lead Screening[19]	✱	✱															
Tuberculosis Testing[21]	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱
Dyslipidemia Screening[22]		✱		✱	←———	●	———→	✱	✱	✱	✱	✱	✱	←———	———	●	———→
STI/HIV Screening[23]							✱	✱	✱	✱	✱	←———	●	———→	✱	✱	✱
Cervical Dysplasia Screening[24]																	●
ORAL HEALTH[25]		●															
Fluoride Varnish[26]	———→																
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

KEY: ● = to be performed ● or ✱ = risk assessment to be performed with appropriate action to follow, if positive ←——● ——→ = range during which a service may be provided

See pages 131 and 132 for footnotes.

Infant, Toddler, Preschool Age – Child Health Form

HEALTH PROFESSIONAL COMPLETE THIS PAGE –
OR PROVIDE COPY OF WELL CHILD PHYSICAL

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

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)

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

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)

Comments:

May use stamp

Signature _____
Circle the Provider Type: **MD DO PA ARNP**

Address: Telephone:

American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures March 2021) https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

PARENT/GUARDIAN **COMPLETE THIS PAGE** **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.

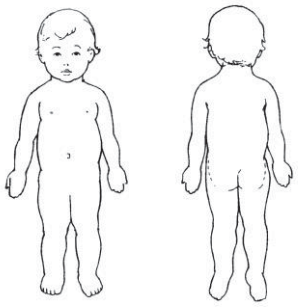
Please describe:

☐ **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 problems with
☐ Skin, birthmarks, Mongolian spots, hair, fingernails or toenails.
Map and describe color/shape of skin markings
birthmarks, scars, moles



☐ Eyes \ vision, glasses
☐ Ears \ hearing, hearing aids or device, earaches, tubes in ears
☐ Nose problems, nosebleeds, runny nose
☐ Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring
☐ Frequent sore throats or tonsillitis
☐ 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.
☐ Nervous system, headaches, seizures, or nervous habits (like twitches)
☐ Needs special equipment.

List equipment:

☐ **Medication** - My child takes medication. (List the name of medication, time medication taken, and the reason medication prescribed).

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

Parent/Guardian Signature Date:

Recommendations for Preventive Pediatric Health Care – Infant, Toddler, and Preschool Age

Bright Futures/American Academy of Pediatrics

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care. Refer to the specific guidance by age as listed in Bright Futures guidelines (Hagan JF, Shaw JS, Duncan PM, eds. Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

	INFANCY								EARLY CHILDHOOD						
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y
HISTORY: Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS: Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●			
Weight for Length		●	●	●	●	●	●	●	●	●	●				
Body Mass Index[5]												●	●	●	●
Blood Pressure[6]		✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	●	●
SENSORY SCREENING: Vision[7]		✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	●	●
Hearing		●[8]	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	●
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT:															
Developmental Screening[9]								●			●		●		
Autism Screening[10]											●	●			
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●
Psychosocial/Behavioral Assessment		●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol and Drug Use Assessment[11]															
Depression Screening[12]															
PHYSICAL EXAMINATION[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[14]**:** Newborn Blood Screening[15]		←———	●	——→											
Critical Congenital Heart Defect Screening[16]		●													
Immunization[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin[18]						✱			●	✱	✱	✱	✱	✱	✱
Lead Screening[19]							✱	✱	● or ✱[20]		✱	● or ✱[20]		✱	✱
Tuberculosis Testing[21]				✱			✱		✱			✱		✱	✱
Dyslipidemia Screening[22]												✱			✱
STI/HIV Screening[23]															
Cervical Dysplasia Screening[24]															
ORAL HEALTH[25]							✱	✱	● or ✱		● or ✱	● or ✱	● or ✱	●	
Fluoride Varnish[26]							←———				●	——→			
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

KEY: ● = to be performed ● or ✱ = risk assessment to be performed with appropriate action to follow, if positive ←——● ——→ = range during which a service may be provided

Footnotes for Recommendations for Preventive Pediatric Health Care

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per the 2009 AAP statement "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Every infant should have a newborn evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in the 2012 AAP statement "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborn infants discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per the 2010 AAP statement "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per the 2007 AAP statement "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3 year olds. Instrument based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See 2016 AAP statement, "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/1.51) and "Procedures for Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/1.52).
8. All newborns should be screened, per the AAP statement "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. See 2006 AAP statement "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).
10. Screening should occur per the 2007 AAP statement "Identification and Evaluation of Children with Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
11. A recommended screening tool is available at http://www.ceasar-boston.org/CRAFFT/index.php.
12. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
13. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See2011 AAP statement "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
14. These may be modified, depending on entry point into schedule and individual need.
15. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf), establish the criteria for and coverage of newborn screening procedures and programs. Follow-up must be provided, as appropriate, by the pediatrician.

16. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).

17. Schedules, per the AAP Committee on Infectious Diseases, are available at: http://aapredbook.aappublications.org/site/resources/izschedules.xhtml. Every visit should be an opportunity to update and complete a child's immunizations.

18. See 2010 AAP statement "Diagnosis and Prevention of Iron Deficiency and Iron Deficiency Anemia in Infants and Young Children (0-3 Years of Age)" (http://pediatrics.aappublications.org/content/126/5/1040.full).

19. For children at risk of lead exposure, see the 2012 CDC Advisory Committee on Childhood Lead Poisoning Prevention statement "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).

20. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.

21. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of AAP Red Book: Report of the Committee on Infectious Diseases. Testing should be performed on recognition of high-risk factors.

22. See AAP-endorsed 2011 guidelines from the National Heart Blood and Lung Institute, "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).

23. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases. Additionally, all adolescents should be screened for HIV according to the AAP statement (http://pediatrics.aappublications.org/content/128/5/1023.full) once between the ages of 16 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.

24. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm). Indications for pelvic examinations prior to age 21 are noted in the 2010 AAP statement "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).

25. Assess if the child has a dental home. If no dental home is identified, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf) and refer to a dental home. If primary water source is deficient in fluoride, consider oral fluoride supplementation. Recommend brushing with fluoride toothpaste in the proper dosage for age. See 2009 AAP statement "Oral Health Risk Assessment Timing and Establishment of the Dental Home" (http://pediatrics.aappublications.org/content/111/5/1113.full), 2014 clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626), and 2014 AAP statement "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224.full).

26. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspsdnch.htm). Once teeth are present, fluoride varnish may be applied to all children every 3-6 months in the primary care or dental office. Indications for fluoride use are noted in the 2014 AAP clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).

Iowa Department of Public Health
Certificate of Immunization Exemption
Medical Exemption

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

The above named applicant qualifies for a medical exemption to immunization for the following reason (select one):

☐ In the opinion of a physician, nurse practitioner, or physician assistant the following required immunization(s) would be injurious to the health and well-being of the applicant or any member of the applicant's family or household (contraindication due to contact with family or household member applies only to MMR and Varicella vaccine). Check only those immunizations which are medically contraindicated:

- ☐ Hep B (Hepatitis B)
- ☐ DTaP (Diphtheria, Tetanus, Pertussis)
- ☐ IPV (Polio)
- ☐ Hib (*haemophilus influenza* type b)
- ☐ PCV (Pneumococcal)
- ☐ MMR (Measles/Rubella)
- ☐ Varicella (Chickenpox)
- ☐ Tdap (Tetanus, Diphtheria, Pertussis)
- ☐ Meningococcal (A, C, W, Y)

If, in the opinion of the physician, nurse practitioner, or physician assistant issuing the medical exemption, the exemption should be terminated or reviewed at a future date, an expiration date shall be recorded on the Certificate of Immunization Exemption.

☐ Administration of the following required vaccine(s) would violate minimum interval spacing of at least 28 days from a dose of a previously received live vaccine. In this circumstance, the exemption shall apply only to an applicant who has not received prior doses of exempted vaccine. An expiration date, not to exceed 60 days, shall be recorded on the certificate. Check only the immunizations which are medically contraindicated:

- ☐ MMR (Measles/Rubella)
- ☐ Varicella (Chickenpox)

Certificate Expiration Date: _____

A child granted a medical exemption may be excluded from child care or school during a disease outbreak. The length of time a child is excluded from child care or school will vary depending on the type of disease and the circumstances surrounding the outbreak, and could range from several days to over a month. A Certificate of Immunization Exemption for medical reasons is valid only when signed by an Iowa licensed physician, nurse practitioner, or physician assistant.

By signing this certificate, I certify the immunizations specified on this certificate would be injurious to the health of the applicant, to a member of the applicant's family or household or the required vaccine would violate the minimum interval spacing.

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

Iowa License Number: _____
Physician (MD or DO), Physician Assistant, or Nurse Practitioner

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

Parent Survey

As part of the Center Leadership Unified for Balance (CLUB) review process, CCR&R has created a survey for parents in of the program. This survey can be sent by CCR&R in the SurveyMonkey platform or you can utilize this paper copy. The information in this survey will be kept confidential and anonymous.

Purpose: To gather information on the history of your program and the perceptions of parents.

Survey Questions	Responses
When you enrolled your child in the center, how was the enrollment process?	☐ 1 please improve ☐ 2 satisfactory ☐ 3 very good ☐ 4 excellent
As a parent or guardian, do you feel welcome in your child's classroom?	☐ 1 please improve ☐ 2 satisfactory ☐ 3 very good ☐ 4 excellent
The teachers and staff greet my child and me by name.	☐ 1 please improve ☐ 2 satisfactory ☐ 3 very good ☐ 4 excellent
I feel informed about how my child is doing in school.	☐ 1 please improve ☐ 2 satisfactory ☐ 3 very good ☐ 4 excellent
I feel comfortable bringing my concerns to the teacher and administration.	☐ 1 please improve ☐ 2 satisfactory ☐ 3 very good ☐ 4 excellent
There are adequate supplies and materials in good condition.	☐ 1 please improve ☐ 2 satisfactory ☐ 3 very good ☐ 4 excellent
How would you rate the performance of the Director?	☐ 1 please improve ☐ 2 satisfactory ☐ 3 very good ☐ 4 excellent
Are the staff caring, friendly and helpful?	☐ 1 please improve ☐ 2 satisfactory ☐ 3 very good ☐ 4 excellent
Are there opportunities for parent involvement?	☐ 1 please improve ☐ 2 satisfactory ☐ 3 very good ☐ 4 excellent
Organization within the center?	☐ 1 please improve ☐ 2 satisfactory ☐ 3 very good ☐ 4 excellent
Is our program up to your expectations of why you chose our program over another program?	☐ 1 please improve ☐ 2 satisfactory ☐ 3 very good ☐ 4 excellent

Notes
If you have any other comments that would help our center provide better quality care, please share below:

Iowa Department of Public Health
Certificate of Immunization Exemption
Religious Exemption

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

A religious exemption may be granted to an applicant only if immunization conflicts with a genuine and sincere religious belief. A Certificate of Immunization Exemption for religious reasons shall be signed by the applicant or, if the applicant is a minor, by the parent or guardian or legally authorized representative. By signing this certificate you are attesting that the immunization conflicts with a genuine and sincere religious belief and that the belief is in fact religious, and not based merely on philosophical, scientific, moral, personal, or medical opposition to immunizations. The Certificate of Immunization Exemption for religious reasons is valid only when notarized. A child granted a religious exemption may be excluded from child care or school during a disease outbreak. The length of time a child is excluded from child care or school will vary depending on the type of disease and the circumstances surrounding the outbreak, and could range from several days to over a month.

By signing this form, I acknowledge the Iowa Department of Public Health has published information regarding immunizations on the Department's website, including:

- Information that failure to complete the required immunizations increases the risk to my child and others of contracting, carrying, and spreading a vaccine-preventable disease; and
- Information that there are children with special health needs attending schools and child care who are unable to be vaccinated or who are at a heightened risk of contracting a vaccine-preventable disease and for whom such a disease could be life-threatening.

Signature: _____ Date: _____
Applicant, Parent or Guardian

State of _____ County of _____

This instrument was acknowledged before me on _____ Stamp or Seal
Date

by _____
Name(s) of Person(s)

Signature of Notary Public: _____

Title (or Rank for Military Personnel): _____

My commission expires: _____

SICK POLICY

We at HCDC understand that it is difficult for a parent/guardian to leave or miss work due to a sick child. In respect to our families and staff members we ask that ill children are kept at home. Therefore, it is suggested that alternative arrangements be made for occasions when your children must remain at home or be picked up due to illness.

Exclusion from HCDC is sometimes necessary to reduce the transmission of illnesses. Mild illnesses are common among young children and infections are often spread before the onset of any symptoms. If any of the symptoms or behaviors listed below occur, we ask families to keep children home. If symptoms begin at the center we ask that children are picked up within 1.5 hours of notification.

Symptoms that will require absence from the program or cause to be sent home:

- Illness that prevents the child from participating comfortably in program activities.
- Illness that results in greater need for care than our educators can provide without compromising the health and safety of other children.
- Fever equal to or higher than 100 degrees that is accompanied by unusual lethargy, irritability, persistent crying, difficult breathing, or other signs of illness.
- Diarrhea, stools with blood or mucus, and/or uncontrolled, unformed stools that cannot be contained in a diaper/underwear or toilet.
- Vomiting
- Conjunctivitis (pink eye with eye discharge) until on antibiotics for 24 hours.
- Impetigo until 24 hours after treatment.
- Strep throat until 24 hours after treatment.
- Head lice until there are no nits in the hair.
- Chickenpox until all lesions have dried and crusted.

Children may return to school when:

- ***They are free of fever, vomiting and diarrhea for a full 24 hours without medication.***

  I.e., if your child has been sent home at 12p.m. on a Monday with a 102 degree fever they may not return to the center until they were fever free for 24 hour without fever reducers like Tylenol or Ibuprofen. The earliest they could return would be 12p.m on Tuesday if they had NO medication. Please ask for clarification if you are unsure of the timeframe.
- They have been treated with an antibiotic for a full 24 hours.
- They are able to participate comfortably in all usual program activities, including outdoor time.

Presence of contagious illnesses will be posted anonymously to keep all families informed.