Scott County Family Y

Child Care & Family Services

EARLY LEARNING CENTERS

Please choose your site:

☐ Davenport Early Learning Center

☐ Palmer Early Learning Center

☐ Newcomb Early Learning Center

☐ Bridgeview Preschool

Thank you for choosing the YMCA Childcare, we are delighted to have you and your family as a member of our YMCA family. Please note we have a Child Care & Family Services Handbook to assist you with any questions you might have. All of our childcare programs are based on our mission to put Judeo-Christian principles into practice through the programs that build healthy spirit, mind, and body for all.

Start Date:_____ Funding Source: ☐ Parent Pay ☐ State Pay

Child's Name:_____ Nickname (if any):_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Birth Date:_____ Age:_____ Sex: ☐ M ☐ F

The following information is required by the Child and Adult Care Food Program the Y participates in.
My child's usual days and times of attendance will be:

	Monday	Tuesday	Wednesday	Thursday	Friday
Arriving at	_____	_____	_____	_____	_____
Leaving at	_____	_____	_____	_____	_____

My child's anticipated meal participation will be:

☐ Breakfast ☐ Lunch ☐ PM Snack

Ethnicity/Racial Identity of Child (Answering this question is voluntary)

Hispanic or Latino	Non-Hispanic or Latino	American Indian	Alaskan Native	Asian	Caucasian	Black or African American	Pacific Islander or Native Hawaiian
☐	☐	☐	☐	☐	☐	☐	☐

In Case of Emergency

Persons to contact in case of emergency if parents are unavailable and are authorized to pick the child up.

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

If there are any custody or restraining orders for person(s) who may attempt to pick up or have contact with the child(ren) while in care at the center, please list the names of the person(s). If there is a custody or restraining order in place, we will need a copy of the document for the file.

Parental Emergency Medical Consent

This form must be presented upon admission for treatment

Child's Name:_____ Birth Date:_____ Age:_____

Parents/Guardians/Custodians with whom the child resides:

Name: _____	Relationship to Child:_____
Address: _____	Employer:_____
City:_____ State:_____ Zip:_____	Department:_____ Work Hours:
Home:_____ Cell:_____	Work:_____ _____
Name: _____	Relationship to Child:_____
Address: _____	Employer:_____
City:_____ State:_____ Zip:_____	Department:_____ Work Hours:
Home:_____ Cell:_____	Work:_____ _____

This form allows parents and guardians to authorize the provision of emergency treatment for the above named child in the event that the child becomes ill or injured while under program authority when parents/guardians cannot be reached. In the event reasonable attempts to contact me at the above listed numbers are not successful, I hereby give consent for the administration of any treatment deemed necessary by:

Physician and Dentist Information

Physician Name:_____	Dentist Name:_____
Address:_____	Address:_____
City:_____ State:_____	City:_____ State:_____
Phone:_____	Phone:_____

In the event that the designated practitioners are not available, then by another licensed physician or dentist and the transfer of the child to_____(SPECIFIC HOSPITAL OF PREFERENCE).

Date of Last Tetanus:_____ Known Allergies:_____

Present Medications:_____

Insurance Company:_____ Policy Holder's ID:_____

This consent will be in effect for one year beginning_____

Signature of Parent or Guardian: _____Date:_____

Signature of Parent or Guardian: _____Date:_____

Child's Name:_____ Birth Date:_____ Age:_____

Waiver of Liability

I understand that I am able and am speaking on behalf of myself and other individuals listed on this application. In consideration of my/our participation in the Scott County Family Childcare program(s) I/we do hereby agree to hold free from any and all liability the YMCA and it's respective officers, employees, and members and do hereby for myself/ourselves, my/our heirs, executors, and administrators, waive, release, and forever discharge any and all rights and claims for damages that I/we may hereafter accrue to me/us arising from, or connected with myself/ourselves to be physically sound having medical approval to participate in the childcare program of the YMCA.

Transportation and Activity Authorizations

I give permission for my child to participate in trips, tours, walks, and special events under the supervision of YMCA staff. Notifications of any activity will be given in advance of said activity. Please note that all Y activity classes that a child has signed up for will be considered a field trip from the center. The Y staff involved in teaching the class is/ are not considered a member of the childcare staff. I further understand the childcare staff will be responsible for preparing each child for lessons including assisting with changing clothes if the class requires special clothing (swim suits, gymnastic outfits, etc.). Children will be supervised at all times and no child will be allowed to go to or from any activity class without the supervision of a staff person from the childcare department.

Parent Payment Agreement

Tuition for all programs is due in advance each Friday for the next week of service. In the Learning Centers and Summer Fun Club, there will not be any deductions for absence or holidays. Kids Club programs are billed according to the school schedule. However, there will be no deductions for snow days. We do not offer part time care in any of our programs. Parents are required to pay an annual registration fee of $25.00. Families will be charged a late pick up fee of $5.00 per every fifteen minutes after 6:00 p.m.. There will be an additional fee in the event of a returned check. An additional summer activity fee of $35.00 is charged in both of the Early Learning Centers. In case of withdrawal of my child from the program, I agree to give the center a two week notice.

Photography Consent

I ☐ DO or ☐ DO NOT give consent to let my child be photographed for use by the YMCA in newspapers or other media for the purpose of advertisement or publicity.

First Aid Consent

I give my permission for staff to give first aid or apply antiseptic ointment if it is deemed necessary.

Permission to Apply Sunscreen to Child

As the parent/guardian of the above child, I recognize that too much sunlight may increase my child's risk of getting skin cancer someday. Therefore, I give my permission for personnel at the **Scott County Family Y** to apply a sunscreen product of SPF-15 or higher to my child, as specified below, when he/she will be playing outside during the months of March through October and between the daily times of 10 a.m. and 4 p.m.. I understand that sunscreen may be applied to exposed skin, including but not limited to the face, tops of the ears, nose, and bare shoulders, arms, and legs. I have checked all applicable information regarding the type and use of sunscreen for my child:

☐ I do not know of any allergies my child has to sunscreen.

☐ Staff may use the sunscreen of their choice following the directions or recommendations printed on the bottle.

☐ I have provided the following brand/type of sunscreen for use on my child: _____

☐ My child is allergic to some sunscreens. Please only use the following brand(s) and type(s) of sunscreen: _____

☐ For medical or other reasons, please do not apply sunscreen to the following areas of my child's body: _____

Parent/Guardian full legal name (print):_____

Parent/Guardian signature:_____ **Date:**_____

Child's Name:_____ Birth Date:_____ Age:_____

Parent/Guardian Interest Sheet

If the parents and other family members of the children are involved in our Early Learning programs everyone benefits. We want you to feel welcome at all meetings, activities, and events. We also want to provide experiences for you and your family that will be informative, useful, and even fun. Please take a few minutes to fill out this form and return it to your child's preschool provider. Check any topics that interest you, check as many as you like. If you have any ideas for meetings or events that are not listed, please add them under the other section.

- ☐ Addictive Behaviors
- ☐ Behavior Management
- ☐ Stress Management
- ☐ Depression in Children
- ☐ Community Library Services and Programs
- ☐ Free Books
- ☐ Free Plays and Performances
- ☐ Music and Finger-plays
- ☐ Craft Activities with Books
- ☐ Adult-Child Interactions to Build Language Skill
- ☐ Time Management
- ☐ Meal Planning and Shopping
- ☐ Child Abuse/Lack of Supervision
- ☐ Transition to Kindergarten
- ☐ Cooking Projects with Children

Other:_____

How often do you read to your child? ☐ Never ☐ Weekly ☐ 2-5 times Weekly ☐ Daily

How many books does your child have at home? ☐ None ☐ 1-10 ☐ 10-25 ☐ 25-50 ☐ 50-100 ☐ 100+

Does your Child have a library card? ☐ Yes ☐ No How many times does your child visit the library/bookmobile monthly?

Best days to attend meetings:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Best times to attend meetings ☐ Mornings ☐ Afternoon ☐ Evenings

What is your primary home language?_____

We are always looking for parents and family members to share their special interests and talents with the children and our parents. Please note below if you have a hobby, interest, or talent you would like to share (e.g. crafts, home repair, car maintenance, cooking) with your name and contact information.

Hobby/Interest/Talent:_____

Name:_____ Phone:_____ Email:_____

Individual Interest Survey

In order to help us meet the individual needs of your children, please complete the following information.

Other children at home:

Name:_____ Age:____ Relationship:_____

Name:_____ Age:____ Relationship:_____

Name:_____ Age:____ Relationship:_____

Name:_____ Age:____ Relationship:_____

Family History: ☐ Married ☐ Single Parent ☐ Divorced ☐ Separated ☐ Foster family

Please select which types of activities your child enjoys:

- ☐ Sports
- ☐ Music
- ☐ Crafts
- ☐ Science
- ☐ Computer
- ☐ Reading/Being read to
- ☐ Drawing
- ☐ Outdoor
- ☐ Puzzles
- ☐ Cooking
- ☐ Table/Card games
- ☐ Make believe (dolls, blocks)

Please describe what works best with your child as a method of behavior management:_____

Does your child have any special skills or needs that we need to know about? _____

Infant, Toddler, Preschool Age - Child Health Form

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Parent/Guardian - Complete this page

Child's Name:	Child's Birth date:	Child Care Facility:
Parent/Guardian Name (#1):	Parent/Guardian Name (#2):	Telephone:
Child's Home Address (#1):	Child's Home Address (#2):	Phone (#1): Phone (#2):
Parent/Guardian (#1) Place of Employment:	Work Address (#1):	Work Phone (#1): Email:
Parent/Guardian (#2) Place of Employment:	Work Address (#2):	Work Phone (#2): Email:

In the event of an emergency, the child care provider is authorized to obtain EMERGENCY MEDICAL or DENTAL CARE even if the child care facility is unable to immediately make contact with the parent/guardian. ☐ **Yes** ☐ **No**

During an emergency, the child care provider is authorized to contact the following person when the parent or guardian cannot be reached.

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

Alternate Emergency contact person's name: _____ **Phone:** _____
Relationship to Child: _____ **Additional Phone:** _____

Child's **Doctor's** Name:	Doctor's Phone:	Hospital of choice:
Doctor's address:	After hours telephone:	Does your child have health insurance? ☐ Yes ☐ No Company: ID #:
Child's **Dentist's** Name:	Dentist's Phone:	Does your child have dental insurance? ☐ Yes ☐ No Company: ID #:
Dentist's address:	After hours telephone:	☐ Help us find a family doctor or dentist ☐ Help us find health or dental insurance
Other health care/mental health specialist name:		Phone:

Infant, Toddler, Preschool Age - Child Health Form (cont.)

Health Professional – Complete this page

Child's name: _____

Date of Birth: _____ 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: _____

Allergies

Environmental: _____

Medication: _____

Food:_____

Insects: _____

Other: _____

Immunization – Please attach:

Iowa Department of Public Health

- ☐ Certificate of Immunization
- ☐ Certificate of Immunization Exemption Medical
- ☐ Certificate of Immunization Exemption Religious
- ☐ TB testing completed (only for high-risk child)

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 ☐Normal

Autism screening ☐Normal

Psychosocial/behavioral ☐Normal

Developmental Referral made today: ☐Yes ☐No

Exam Results
(N=normal limits) otherwise describe

HEENT ☐Normal Oral/Teeth ☐Normal

Date of Dental exam _____

Oral Health/Dental Referral made today: ☐Yes ☐No

Heart ☐Normal Genitalia ☐Normal

Lungs ☐Normal Skin/Lymph nodes ☐ Normal

Neurological ☐Normal Stomach/Abdomen ☐ Normal

Extremities, Joints, Muscles, Spine ☐ Normal

HC Provider Comments:

Medication

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

Medicine:	Dosage:
☐ Diaper cream	_____
☐ 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 (please attach)

Type of plan _____

Provider Signature (May use stamp)

_____

Circle the Provider Credential Type: MD DO PA ARNP

Address: _____

Telephone: _____