Regina Pre-K, Preschool & Daycare, Early Childhood Center
2140 Rochester Ave., Iowa City, IA 52245

LETTER OF FINANCIAL AGREEMENT WITH REGINA PRE-K/PRESCHOOL/DAYCARE FAMILIES

Regina Pre-Kindergarten, Preschool & Daycare agrees to provide the following services (check appropriate):

____ ****DAYCARE: $260 a week Monday through Friday**
Fee includes 5 day PreK/ Preschool session, Lunch and am/pm Snack
Tuition is figured as a weekly fee. Payments are due on the Monday of each week.
No refunds are given for illness, vacations, holidays, or snow days.

____ **PRE-K AM Monday-Friday: $400 a month, 5 day program (4-5 year olds)**

____ **PRE-K-AM MON/WED/FRI: $240 a month 3 day program (4-5 year olds)**

____ **PRE-K-PM MON/WED/FRI: $200 a month 3 day program (4-5 year olds)**

____ **PRESCHOOL MON./WED./FRI: $240.a month** Or_____ **TUES/THURS: $195 a month (3-4 year olds)**

Tuition is figured as a monthly fee. It may be paid in full at registration, or in nine monthly payments due on the first of each month, beginning with September and ending in May.
No refunds are given for illness, vacation, holidays, or snow days.

PAYMENT DUE

Preschool and Pre-Kindergarten: Upon receipt of statement or the first Monday of each Month.
******Daycare (payment includes 5 day Preschool/ Pre-K : Upon receipt of statement or Monday of each Week.

TERMS AND CONDITIONS OF THIS AGREEMENT:

In the event of non-payment, Regina Early Childhood Center reserves the right to discontinue service. Parents will be given up to one month to make restitution. If after one month, payment has not been made or a payment arrangement has been made with the business office, the parents will be asked to withdraw their child from preschool or daycare. Thank you!

Mary Pechous
Preschool Director

Alan Opheim
Business Manager

Please mark the appropriate fee above and sign below:

I accept these terms of payment and agree to all conditions contained within this statement.

____

Name Signature Date

Iowa Department of Public Health
Certificate of Immunization

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

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

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

Signature: __________ Date: __________

Physician, Physician Assistant, Nurse, or Certified Medical Assistant

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

	Vaccine	Date Given	Doctor / Clinic / Source
Diphtheria, Tetanus, Pertussis *DTaP/DTP/DT/ Td/Tdap*			
Polio *IPV/OPV*			
Measles, Mumps, Rubella *MMR*			
***Haemophilus influenzae* type b** *Hib*			
Hepatitis B			
Varicella Chicken Pox If applicant has a history of natural disease write "Immune to Varicella"			
Pneumococcal *PCV/PPV*			

	Vaccine	Date Given	Doctor / Clinic / Source
Meningococcal *MCV4/MPSV4*			
Hepatitis A			
Rotavirus			
Human Papilloma Virus *HPV*			
Other			

Licensed Child Care Requirements

4 through 5 months
1 dose Diphtheria/Tetanus/Pertussis
1 dose Polio
1 dose Hib
1 dose Pneumococcal

6 through 11 months
2 doses Diphtheria/Tetanus/Pertussis
2 doses Polio
2 doses Hib
2 doses Pneumococcal

12 through 18 months
3 doses Diphtheria/Tetanus/Pertussis
2 doses Polio
2 doses Hib or 1 dose received at ≥ 15 months of age.
3 doses Pneumococcal if received 1 or 2 doses < 12 months of age; or 2 doses if received 1 dose ≥ 12 months of age or has not received this vaccine before.

19 through 23 months
4 doses Diphtheria/Tetanus/Pertussis
3 doses Polio
3 doses Hib with the final dose in the series ≥ 12 months of age, or 1 dose received ≥ 15 months of age.
1 dose Measles/Rubella ≥ 12 months of age.
1 dose Varicella ≥ 12 months of age if born on or after September 15, 1997, or a reliable history of natural disease.
4 doses Pneumococcal; or 3 doses if received 1 or 2 doses < 12 months of age; or 2 doses if received 1 dose ≥ 12 months of age or has not received this vaccine before.

24 months and older
Same requirements as the 19-23 months except **4 doses Pneumococcal** if received 3 doses < 12 months of age; or 3 doses if received 2 doses < 12 months of age; or 2 doses if received 1 dose < 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.

Elementary/Secondary School Requirements

4 years of age and older
5 doses Diphtheria/Tetanus/Pertussis with at least 1 dose received ≥ 4 years of age if born on or after September 15, 2003; or 4 doses, with 1 dose received ≥ 4 years of age if born after September 15, 2000, but before September 15, 2003; or 3 doses, with 1 dose received ≥ 4 years of age if born on or before September 15, 2000.
4 doses Polio with 1 dose received ≥ 4 years of age if born on or after September 15, 2003; or 3 doses, with 1 dose received ≥ 4 years of age if born on or before September 15, 2003.
2 doses Measles/Rubella; the first dose shall have been received ≥ 12 months of age; the second dose shall have been received ≥ 28 days after the first.
3 doses Hepatitis B if born on or after July 1, 1994.
2 doses Varicella ≥ 12 months of age if born on or after September 15, 2003; or 1 dose received ≥ 12 months of age if born on or after September 15, 1997, but before September 15, 2003, unless the applicant has a reliable history of natural disease.

Rev. 12/2008

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PHYSICAL EXAMINATION FORM

Physician: ___________________________________
Facility: _____________________________________
Address: _____________________________________
Child's Full Name: ____________________________
Address: _____________________________________

Physical Examination (to be completed by physician or designee)

Age ________Height __________Weight _______
Skin _____________________________________
Eye________________ Nose________________
Ears _______________ (L) TM _______________
Mouth: Teeth________ Gingiva _______________
Throat______________ Neck_________________
Heart ____________________________________
Lungs ____________________________________
Genitalia _________________________________
Spine and Back ____________________________
Neuromuscular _____________________________

Urinalysis ________________________________
Head and Scalp ____________________________
Lymph Nodes ______________________________
(R) TM ___________________________________
Palate ____________________________________
Chest ____________________________________
B.P. __________ Femoral Pulse ______________
Abdomen _________________________________
Rectum, Anus _____________________________
Extremities ________________________________
Gait _____________________________________

Vision: (R) eye ____________________ (L) eye ____________________ Both _____________________
Hearing: Normal _________________ Abnormal ________________ Not Tested __________________

If Needed: *Hemoglobin or Hematocrit* _______
Sickle Cell screening ____________________
Lead Screening ________________________

Tuberculin Screening ____________________
Development Testing ____________________
Other ___________________________________

Allergies ____

Summery of findings and recommendations: I have examined *(name of child)* _____________________
He/She is ____ is not____ physically and emotionally able to participate in your program.
Additional Comments: ____
____

Date of the physical examination: ______________________

____
Signature of Physician or Designee

____
Date

Parent please complete the following:
Diseases child has had ____
____
Any special health needs (susceptible to colds, recurrent ear infections, etc.) _______________________
____

Regina Pre-K, Preschool & Daycare, Early Childhood Center
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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 PH#s: ____________________ or ____________________ have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by Physician: __________________________at PH#: __________________________ or Dentist: ____________________ at PH#: ____________________ 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? Yes/No (Circle One) Names:____

3. Medical Information ***(Please complete in full)***

Physician name ___________________________________ Dentist name: ___________________________________
Street Address ___________________________________ Street Address: ___________________________________
City, State, Zip ___________________________________ City, State, Zip ___________________________________
Phone Number ___________________________________ Phone Number ___________________________________

Date of Last Tetanus: ______________________________ Known Allergies: ___________________________________

Current Medications: ____

Insurance Company: ______________________________ Policy Holder's I.D.: ________________________________

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

Facility: *Regina Early Childhood Center*
Child's Full Name: ______________________________

I hereby give permission for my child to leave the center with the following persons named below. It is the responsibility of the parents to notify the center, in writing, of any changes.

Mother:______________________________ Phone #:__________
Father:______________________________ Phone #:__________
Emgcy. Care Prvdr:____________________ Relationship:____________ Phone #:__________
Other:________________________________ Relationship:____________ Phone #:__________
Parent/Guardian Signature_______________________ Date_______________________

If there is a separation, or custody problem, which Regina Staff should be aware of, please explain:
____

Name of person(s) who may not pick up the child: ______________________________
____

TRAVEL AUTHORIZATION RELEASE

I/we do ____, do not ____, give consent for ________________________ to participate in field trips with Regina Preschool Teachers. I/we do reserve the right to be notified before each field trip that involves travel in or out of town. I release Regina Preschool/Daycare of any liability unless negligence is proven. I am aware that Regina Preschool Teachers may take children on walks within the vicinity of the program.

______________________________ ______________________
Parent/Guardian Signature Date

PHOTOGRAPHY RELEASE

I/we do ____, do not ____, give consent that Regina Preschool/Daycare may take photographs of our child: ________________________ and we consent that Regina may use the photographs of our child for display or promoting the purpose of the Center. We understand that no financial benefits from the use of the photographs are obligated to be paid to us.

______________________________ ______________________
Parent/Guardian Signature Date

CONFIRMATION OF HANDBOOK RECEIPT

I acknowledge that I have read the Regina PreK/Preschool & Daycare Handbook and have access to a copy for reference on either the Regina Preschool Website or in hard copy (by request to the director). I agree to follow all policies outlined within the Regina Preschool Handbook, with special attention to those regarding parental responsibilities. Our handbook clearly outlines our program and the responsibilities of parents in order to facilitate the safety of all children in our program. Please feel free to ask the director any questions regarding procedure and policy.

____
Name Signature Date

Parent's/Guardian's Permission
To Apply Sunscreen & Bug Spray To Child

Name of Child: ____

As the parent or guardian of the above child, I recognize that overexposure to the sun's rays without adequate protection may increase my child's risk of getting skin cancer. Regular use of sunscreen can help to prevent skin damage. Further, I recognize at times playground areas may have mosquitoes, gnats, flies and other insects, which can make outdoor play uncomfortable. Usage of a small amount of bug spray can make play more comfortable and lower the chances of contracting insect spread diseases. Therefore, I give my permission for personnel at:

Regina Early Childhood Center

to apply *Bug Soother (Deet Free)* when personnel deems necessary and to apply a sunscreen product of SPF-15 or higher to my child, as specified below when he/she will be playing outside especially during the months of April-September between the daily times of 10am to 4pm.. 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 understand that bug spray may be applied to exposed skin on the legs, arms, and neck. I have checked all applicable information regarding the type and use of sunscreen and bug spray for my child:

❑ I do not know of any allergies my child has to sunscreen or bug spray.

❑ Staff may use the sunscreen of their choice and Bug Soother (Deet Free) following the directions and recommendations printed on the bottles.

❑ I have provided the following brands/types of sunscreen and/or bug spray for use on my child:

____

❑ My child is allergic to some sun screens/bug sprays. Please use only the following brand(s) and

type(s) of sunscreen/bug sprays:____

❑ For medical or other reasons, please do not apply sunscreen/bug spray to the following areas of

my child's body: ____

Parent/Guardian full name (print): ____

Parent/Guardian
signature:____Date:______________

Your child is enrolled for care in a child care center that participates in the Child and Adult Care Food Program (CACFP). By participating in this Program, the center is meeting Federal meal pattern requirements and receiving reimbursement to assist with food costs. The CACFP requires that parents provide CACFP enrollment information on an annual basis. This form will be placed in our files and treated as confidential information.

Revised 7/2014

Iowa Child and Adult Care Food Program
Child Care Enrollment Form

		Times of Care		Regular Days of Care							Meals Served During Care						Ethnicity/Race*	
Last Name, First Name	**Date of Birth**	**Arrival**	**Departure**	**M**	**T**	**W**	**Th**	**F**	**S**	**S**	**B**	**AM Sn**	**Lu**	**PM Sn**	**D**	**E Sn**	**Ethnicity**	**Race**

*Ethnicity (Select one and enter in the chart above): H=Hispanic or Latino or N=Not Hispanic or Latino
Race (Select one or more and enter in the chart above): W=White, B=Black or African American, I=American Indian or Alaska Native, A=Asian, and P=Pacific Islander
This information is requested by the Federal Government in order to monitor compliance with civil rights law. You are not required to furnish this information, but are encouraged to do so. The law requires that a program recipient may neither discriminate on the basis of this information nor on whether you choose to furnish it. However, if you choose not to furnish it, under Federal regulations, this program representative is required to note race/ethnicity on the basis of visual observation or surname.

Infants only (0 to 12 months): ❑ I am not enrolling an infant (skip this section)

As a participant in a USDA Child Nutrition Program, our center offers meals to children of all ages. Infant feeding is based on current nutrition guidelines. Infant foods are appropriate for the age and developmental readiness of your infant. Please select (X) your choice(s) of the following options that will fulfill your infant's food needs.

❑ I will provide breast milk for my infant. Center formula may be used to supplement feedings if necessary: ❑ Yes ❑ No

❑ I will provide infant formula for my infant. Name of formula: ____________________

❑ I accept the center's formula for my infant. Name of formula: ________________________

❑ I will provide a statement from a medical authority for non-reimbursable formula. Name of formula: ____

❑ I accept the center's solid foods (appropriately textured) to be served to my infant as s/he is ready for them, and after I have discussed it with the caregiver.

❑ I will provide solid foods for my infant*. The center may supplement with additional solid foods when my infant needs them: ❑ Yes ❑ No

*Meals cannot be reimbursed by the CACFP when parents provide solid foods except for medical reasons. DHS licensed centers are required to follow CACFP infant meal pattern requirements regardless of who supplies the food. Your center can provide a copy of the CACFP infant meal pattern and a list of reimbursable foods upon request.

Parent Signature_______________________________________ Date:___________

Parent Signature_______________________________________ Date:___________ (Make any needed changes above, sign and date)

Parent Signature_______________________________________ Date:___________ (Make any needed changes above, sign and date)

USDA is an equal opportunity provider and employer.

This form is available in Spanish in "Download Forms" on the website where claims are submitted