

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		
Vaccella Chicken Pox If applicant has a history of natural disease write "Immune to Vaccella"		
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 14 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 Vaccella ≥ 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, 2003.
 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 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 Vaccella ≥ 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.

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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#: _____ 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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Regina Pre-K, Preschool & Daycare, Early Childhood Center
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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

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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

Last Name, First Name	Date of Birth	Times of Care		Regular Days of Care							Meals Served During Care						Ethnicity/Race*	
		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