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!

Barbara Meyer
Preschool Director

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			

	Vaccine	Date Given	Doctor / Clinic / Source
Varicella Chicken Pox *If applicant has a history of natural disease write "Immune to Varicella"*			
Pneumococcal PCV/PPSV			
Meningococcal MCV/MPSV/ Mening B			
Hepatitis A			
Rotavirus			
Human Papilloma Virus HPV			
Other			

January 2013

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 if the applicant received 1 dose before 15 months of age; or 1 dose if 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 2 doses if only 1 dose received before 15 months of age; or 1 dose if received when the applicant is 15 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 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]	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, unless the applicant has a reliable history of natural disease.
	24 months of age 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 2 doses if only 1 dose received before 15 months of age; or 1 dose if received when the applicant is 15 months of age or older. **Hib vaccine is not required 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 24 months of age; or 2 doses if the applicant received 1 dose before 24 months of age; or 1 dose if the applicant did not receive any doses before 24 months of age. **Pneumococcal vaccine is not required for persons 60 months of age or older.**
		Measles/Rubella[1]	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, 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[4, 5]	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 [2]; 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 on or before September 15, 2003[2]; 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 after September 15, 2003 [2, 3];and 1 time dose of tetanus/diphtheria/acellular pertussis-containing vaccine (Tdap) for the applicant in grades 7 and above, if born after September 15, 2000; regardless of the interval since the last tetanus/diphtheria-containing vaccine.
		Polio	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[7] ; 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[6] **Polio vaccine is not required for persons 18 years of age or older.**
		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
		Varicella	1 dose received on or after 12 months of age if the applicant was born on or after September 15, 1997, but born on or before September 15, 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 after September 15, 2003, unless the applicant has a reliable history of natural disease.[8]
		Meningococcal (A, C, W, Y)	1 dose of meningococcal vaccine received on or after 10 years of age for the applicant in grades 7 and above, if born after September 15, 2004; and 2 doses of meningococcal vaccines for the applicant in grade 12, if born after September 15, 1999; or 1 dose if received when the applicant is 16 years of age or older.

1 Mumps vaccine may be included in measles/rubella-containing vaccine.

2 DTaP is not indicated for persons 7 years of age or older, therefore, a tetanus and diphtheria-containing vaccine should be used.

3 The 5th dose of DTaP is not necessary if the 4th dose was 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 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.

5 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.

6 If an applicant received an all-inactivated poliovirus (IPV) or all-oral poliovirus (OPV) series, a 4th dose is not necessary if the 3rd dose was administered on or after 4 years of age.

7 If both OPV and IPV were administered as part of the series, a total of 4 doses are required.

8 Administer 2 doses of varicella vaccine, at least 3 months apart, to applicants less than 13 years of age. Do not repeat the 2nd dose if administered 28 days or greater from 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.

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

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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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2140 Rochester Ave., Iowa City, IA 52245

PICK-UP PERMISSION FORM

Facility: *Regina Preschool Daycare*
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 be notified before each field trip that involves travel 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 to parks without prior notice.

_____ _____
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 in 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 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/Guardian Permission To Apply Sunscreen, Bug Spray & Lotion To Child

Name of Child: _____

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

Therefore, I give permission for personnel at **Regina Preschool & Daycare** to apply DEET Free Bug Soother or similar product when staff deem necessary. Staff can also apply a sunscreen product of SPF-15 or higher to my child SPF 50 Rocky Mountain Sunscreen Lotion (no Oxybenzone, no Octinoxate, no added fragrance, no gluten, broad spectrum, water resistant 80 min) or similar product as specified 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: 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. Staff can apply a non-medicated lotion (Aveeno, Lubriderm or similar product) as necessary/requested.

☐ I give permission for the staff to apply hand lotion to my child when necessary/requested.

I have read 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, bug spray or lotion.

☐ Staff may use DEET Free Bug Soother & SPF 50 Rock Mountain Sunscreen Lotion or similar product, following the directions and recommendations printed on the product.

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

_____

☐ For medical or other reasons, please **do not** apply sunscreen/bug spray to my child.

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