Registration Form

Child's Name_____

Date of Birth_____

Gender_____

Date_____

Parent Name_____

Email_____

Address_____

Phone_____

Father's Work _____

Father's work phone_____

Father''s cell phone_____

Mother's work _____

Mother's work phone_____

Mother's cell phone_____

Authorize Release Form

Child's Name_____

I authorize my child to be released from Precious Lambs to the following people. Authorized people on the list may be asked to show a driver's license as ID. Please do not list parents as both are legally authorized to pick-up the child unless we have a court document.

Person 1
Name_____

Phone number_____

Person 2
Name_____

Phone number_____

Person 3
Name_____

Phone number_____

Date_____

Parent's Signature_____

Emergency Care Consent

Child's name_____

While my child is under the care and supervision of Precious Lambs Childcare, I give permission for my child to receive First Aid/CPR and Heimlich from trained and certified staff.

In case of illness or an accident while my child is under the care and supervision of Precious Lambs, I give my permission to the director or acting director to take whatever steps may be necessary to obtain emergency medical care if warranted.
It is understood that in some medical situations the staff will need to contact the paramedics before the parents.
I agree to pay for the expenses incurred during emergency medical care and treatments.

I agree_____

Date_____

Parent's signature_____

Photo Release

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

Parent signature_____

_____I decline the photo release. Do not photograph my child while in the child care program.

Parent signature_____

Iowa Department of Human Services

Child Care Provider Physical Examination Report

Child Care Center Personnel ◆ Child Development Home Providers

Name	Date of Examination

Patient may:

- ✓ have very frequent contact with children (infant through school-age) in care.
- ✓ be responsible for children's physical care and social development during day and nighttime hours.
- ✓ need to lift children, bend, and stand for long periods of time.

Child Care Provider Health Concerns (Please check all that apply.)

- ☐ Allergies
- ☐ Breathing problems (asthma, emphysema)
- ☐ Diabetes or problems like thyroid, other
- ☐ Heart, blood pressure problems
- ☐ Vision
- ☐ Illegal or prescription drug abuse
- ☐ Neurologic problems (epilepsy, Parkinsonism, other)
- ☐ Smoking or alcohol use
- ☐ Susceptibility to infection, illness
- ☐ Stomach or bowel problems
- ☐ Skin problems (eczema, rashes, conditions incompatible with frequent hand washing, other)
- ☐ Emotional or nervous problems (depression, difficulty handling stress)
- ☐ Musculoskeletal problems (low back pain, susceptibility to back injury, neck problems, arthritis)
- ☐ Hearing or difficulty hearing in a noisy environment
- ☐ Other (explain):_____

_____

_____

Immunization Status

All child care employees and providers shall consult with their physician regarding the receipt of age appropriate immunizations in accordance with the current Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule. Individuals involved in the provision of child care often come in contact with very young children, whom may or may not be fully immunized against vaccine-preventable diseases. It is essential every child care employee and provider discuss with their physician the benefits and risks associated with receiving or not receiving all ACIP age appropriate immunizations before becoming involved in a child care setting.

(PHYSICIAN MUST CHECK ONE AND DATE)

- ☐ Patient's immunization history was reviewed and patient is current with all ACIP recommended immunizations.
- ☐ Patient received consultation regarding the receipt of age appropriate immunizations in accordance with the current ACIP recommended immunization schedule and declined the following recommended vaccinations:

_____

_____

Date:_____

Tuberculosis Screening

All child care employees and providers shall receive a baseline screening for Tuberculosis. Baseline screening shall consist of two components:

1. Assessing for current symptoms of active TB disease.
2. Screening for risk factors associated with TB.

Those individuals identified as belonging to a defined high-risk group or who have signs or symptoms consistent with TB disease shall be evaluated for TB infection and TB disease.

(PHYSICIAN MUST COMPLETE AND CHECK AND DATE BOTH BOXES)

☐ TB signs and symptoms screen completed Date:_____

☐ TB risk factor screen completed Date:_____

** ***Tuberculosis medical consultation and TB medications can be accessed by calling the Iowa Department of Public Health, Tuberculosis Control Program at 515-281-8636 or 515-281-7504.***

Other Communicable Diseases and Overall Health Status

Does the individual have a known communicable disease or other health conditions that poses a threat to the health, safety, or well-being of children? ☐ Yes ☐ No **(If yes, describe in detail below.)**

Does the child care provider have a condition that limits the provider's ability to safely supervise or evacuate multiple dependent children in case of emergency? ☐ Yes ☐ No **(If yes, describe in detail below.)**

_____

_____

_____

Conclusion

☐ Individual may be involved with child care

☐ Individual may be involved with child care, with the following accommodations and restrictions (please describe below)

☐ Individual may not be involved with child care

Necessary Accommodations or Restrictions to Meet the Demands of Providing Child Care

(Please detail.)

_____

_____

_____

Health Care Provider Signature	Date
Mailing Address	Telephone
Provider Type: ☐ MD ☐ DO ☐ PA ☐ ARNP	Iowa License Number