



Little Eagles Nest Learning Center Infant Social Resume

Child's Name _____

Social/Emotional Development

Describe your child's temperament: (i.e. colic, likes to cuddle) _____

What signs does your child give of being hungry, tired or overstimulated?
(i.e. pulls at ears, rubs eyes)

Does your child separate easily from you? Yes No

Please comment: _____

Does he/she accept new people and experiences easily? Yes No

Please comment: _____

Is your child affectionate? Yes No

Please comment: _____

Is your child afraid of anything? Yes No

Please comment: _____

Does your child have a favorite toy, blanket or soother? Yes No

Please identify: _____

Does your child spend time with other children? Yes No

Please comment: (who, when, how much) _____

What activities does your child enjoy? _____

Diapering

What type of diapers does your child use? _____

Describe your child's diapering routine (include double diapering, liners,
creams, powders etc.) _____

Is your child prone to diaper rash? Yes No

Treatment: _____

Sleep

Does your child have a regular bedtime schedule? _____

What time does your child usually go to bed at night? _____

What time does your child usually wake up in the morning? _____

What is your child's usual nap routine? (Include how many, length, place, and time)

Does your child usually cry when going to sleep? Yes No

If yes, for how long? _____

Are there any favorite items that your child needs to go to sleep each day (pacifier, pillow, blanket, teddy bear, etc.)? _____

Where does your child normally sleep? _____

What is your child's disposition upon waking (happy, clingy, slow to wake, etc.)? _____

Food

Is your child breast-fed? Yes No

If yes:

Do you plan to continue breast feeding? Yes No

If yes, how do you plan to carry this out? _____

What is your child's feeding schedule? _____

Do you supplement? _____

Is your child bottle-fed? Yes No

If yes: What is your child's bottle feeding schedule?

Liquids	Type	Amount	Times
Formula			
Milk			
Milk			
Milk			
Water			
Water			

What position does your child like to be in while bottle feeding? _____

What position does your child like to be in while being burped? _____

Has your child been introduced to solids? Yes No

If yes, what type? baby food table food

What is your child's feeding schedule:

Solids	Type	Consistency	Amount	Times
Cereal				
Cereal				
Cereal				
Vegetable				
Fruit				
Meat				
Meat				
Snack				
Snack				

Does your child have any food sensitivities? Yes No

If yes, please identify: _____

What foods does your child like/dislike? _____

Are there any foods your child should not be fed?

How does your child sit at the table (high-chair, booster seat, etc.)?

Other Information:

Please provide any other information relating to your child that would be helpful in understanding and caring for your child:

Date: ___/___/___
M D Y

Parent/Guardian signature

Emergency Medical Treatment Authorization/Consent Form
Please fill this form out completely or it will be returned to you to finish.

This form was completed on _____

Child's Full Name _____
Birth Date _____
Child's Age _____
Child's Sex _____

I, _____ parent or guardian of the child named above give my permission to _____, child care center, to secure and authorize such emergency medical care, emergency dental care and treatment as my child might require while under the Center's supervision. I also authorize the Center to administer emergency care or treatment as required, until emergency medical assistance arrives. I also agree to pay all the costs and fees contingent on any emergency medical care and treatment for my child as secured or authorized under this consent.

NOTE: Every effort will be made to notify parents immediately in case of emergency. In the event of an emergency, it would be necessary to have the following information:

Name of Parent or Legal Guardian: _____	
Address: _____	
Phone Numbers: _____	Home: _____
Cell: _____	Work/School _____
Name of Parent or Legal Guardian: _____	
Address: _____	
Phone Numbers: _____	Home: _____
Cell: _____	Work/School _____

Doctor: _____
Doctor's Address: _____
Doctor's Phone: _____
Preferred Hospital to Contact: _____
Dentist: _____
Dentist's Address: _____
Dentist's Phone: _____

Present medication(s): _____
Known allergies: _____
Insurance: _____

Physical on child completed on _____
Immunization records give to center on _____
If your child's religious affiliation is contrary to medical treatment or immunization requirements, you provided the center with a notarized statement on _____

The following individuals may be contacted in case of emergency and my child may be released to them:

Name: _____
Address: _____
Phone Numbers: _____ Home: _____
Cell: _____ Work/School _____
Relationship to child _____

Name: _____
Address: _____
Phone Numbers: _____ Home: _____
Cell: _____ Work/School _____
Relationship to child _____

Name: _____
Address: _____
Home Phone Numbers: _____ Home: _____
Cell: _____ Work/School _____
Relationship to child _____

Name: _____
Address: _____
Phone Numbers: _____ Home: _____
Cell: _____ Work/School _____
Relationship to child _____

Please circle your response and fill in the blank if applicable.

I do or do not give consent for my child to attend center-sponsored field trips. This may include walking, car, van, bus or public transportation.

I do or do not give consent for center staff to transport my child to and from school in a center-owned vehicle using only one staff.

I do or do not give consent for my child to attend non center activities. My child will attend the following non center activities: _____

I do or do not give consent for sun block to be applied to my child's skin. If you have a preference on sun screen you must provide it with the child's name written on the container in a permanent marker. Please list the preferred sun screen if applicable _____

I do or do not give consent for my child's picture to be taken.

I do or do not give consent for my child to be videotaped.

Parent/Legal Guardian's Signature _____ Date _____

Parent/Legal Guardian's Signature _____ Date _____

Infant, Toddler, Preschool Age – Child Health Exam Form

PARENTS/GUARDIAN COMPLETE PAGES 1 and 2 – Child Information

Child's name		Child's birthdate	Name of center, provider, or preschool Telephone #
Parent 1 name		Parent 2 name	
Child home address #1		Telephone # 1	
Child home address #2		Telephone #2	
Where parent # 1 works	Work address	Home phone # Work # Pager # Cellular # Home email Work email	
Where parent # 2 works	Work address	Home phone # Work # Pager # Cellular # Home email Work email	
<p>In the event of an emergency, the child care provider is authorized to obtain EMERGENCY MEDICAL or DENTAL CARE even if the child care center is unable to immediately make contact with the parent/guardian. <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>During an emergency the child care provider is authorized to contact the following person when parent or guardian cannot be reached. Parent/Guardian Signature: _____ Date _____ Alternate emergency contact person's name: _____ Phone number: _____ Relationship to child: _____ Cellular number: _____</p>			
Child's doctor's name	Doctor telephone # 1	Hospital choice	
Doctor's address	After hours telephone #	Does child have health insurance? <input type="checkbox"/> Yes, Company _____ ID #	
Child's dentist's name	Dentist Telephone # 1	Does child have dental insurance? <input type="checkbox"/> Yes, Company _____ ID#	
Dentist's Address	After hours telephone #	<input type="checkbox"/> NO, we do not have health insurance. <input type="checkbox"/> NO, we do not have dental insurance.	
Other health care specialist name	Telephone #	<input type="checkbox"/> Please help us find health or dental insurance.	
Type of specialty			

Child Name:

PARENTS COMPLETE THIS PAGE

Parents: Tell us about your child's health. Place an **X** in the box if the sentence applies to your child. Check *all* that apply to your child. This will help your doctor plan your child's physical exam.

Growth

I am concerned about my child's growth.

Appetite

I am concerned about my child's eating / feeding habits or appetite.

Rest -

I am concerned about the amount of sleep my child needs.

Illness/Surgery/Injury - My child

had a serious illness, injury, or surgery. *Please describe.*

Physical Activity - My child

must restrict physical activity. *Please describe.*

Development and Learning

I am concerned about my child's behavior, development, or learning. *Please describe:*

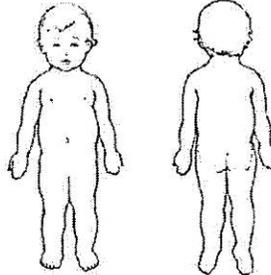
Medication - My child takes medication. List the name, time medication taken, and the reason medication prescribed.

Child's Name: _____

Body Health - My child has problems with

Skin, birthmarks, Mongolian spots, hair, fingernails or toenails.

Map and describe color/shape of skin markings birthmarks, scars, moles



- Eyes \ vision, glasses
- Ears \ hearing, hearing aides or device, ear-aches, tubes in ears
- Nose problems, nosebleeds, runny nose
- Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring
- Frequent sore throats or tonsillitis
- Breathing problems, asthma, cough, croup
- Heart, heart murmur
- Stomach aches, upset stomach, colic, spitting up
- Using toilet, toilet training, urinating
- Bones, muscles, movement, pain with moving
- Mobility, uses assistive equipment
- Nervous system, headaches, seizures, or nervous habits (like twitches)
- Needs special equipment. *Please describe:*

Allergies-My child has allergies (medicine, food, dust, mold, pollen, insects, animals, etc.).

Please describe:

Parent questions or comments for the health care provider:

Iowa Child Care Infant, Toddler, Preschool Age – Child Health Exam Form

HEALTH PROFESSIONAL COMPLETE THIS PAGE¹

Child's Name: _____

Birthdate: _____ Age today: _____

Date of Exam: _____

Height/Length: _____

Weight: _____

Head Circumference—for children age 2 yr and under: _____

Blood Pressure—start @ age 3 yr: _____

Hgb or Hct—anytime between 6-9 mo: _____

Blood Lead Level—start @ 12 mo: _____

Sensory Screening:

Vision: Right eye _____ Left eye _____

Hearing: Right ear _____ Left ear _____

Tympanometry (may attach results)

Developmental Screening²:

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

Oral Health/Dental Referral Made Today: Yes No

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Immunization: May attach a copy of Iowa Department of Public Health Immunization Certificate

DtaP/DTP/Td	MMR
Hepatitis B	Pneumococcal
HIB	Varicella
Polio	Other

Influenza

TB testing (only for high-risk child)

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

Medication Name	Dosage
<input type="checkbox"/> Cough medication	
<input type="checkbox"/> Diaper crème:	
<input type="checkbox"/> Fever or Pain reliever:	
<input type="checkbox"/> Sunscreen:	
<input type="checkbox"/> Other	

Other Medication should be listed with written instructions for use in child care.

Referrals made:

Referred to **hawk-i** today 1-800-257-8563

Other: _____

Health Provider Assessment Statement:

The child may participate in developmentally appropriate child care/preschool with **NO** health-related restrictions.

The child may participate in developmentally appropriate child care/preschool **with the following restrictions:**

Signature _____
 Circle the Provider Credential Type: MD DO PA ARNP

¹ Iowa Child Care Regulations require an admission physical exam report within the previous year. Annually thereafter, a statement of health condition signed by an approved health care provider. The American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (RE9939, March 2000) www.aap.org

² Developmental screening procedures were expanded to include autism, developmental surveillance, and psychosocial/behavioral screening July 2009 by the Iowa EPSDT Medicaid program. Toll-free 800-383-3826.

Health Care Provider comments or instructions:

Child's name: _____

Iowa Health Care Provider -- Guide to Iowa Recommendations for Preventive Pediatric Health Care³

Health Provider's Guide	AGE ⁴											
	1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	2 yr	3 yr	4 yr	5 yr
History: Initial and Interval	●	●	●	●	●	●	●	●	●	●	●	●
Physical Exam	●	●	●	●	●	●	●	●	●	●	●	●
Measurement: Height/ Weight	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference	●	●	●	●	●	●	●	●	●			
Blood Pressure										●	●	●
Nutrition Assess/Educate	●	●	●	●	●	●	●	●	●	●	●	●
Oral Health Assessment ⁵	●	●	●	●	●	●	●	●	●	●	●	●
Development and Behavioral Assessment	●	●	●	●	●	●	●	●	●	●	●	●
Developmental Screening					●			●		●		
Autism Screening								●				
Developmental Surveillance	●	●	●	●		●	●		●		●	●
Psychosocial/behavioral Assessment	●	●	●	●	●	●	●	●	●	●	●	●
Sensory Screen: Vision	S	S	S	S	S	S	S	S	S	O	O	O
Hearing ⁶	S	S	S	S	S	S	S	S	S	S	O	O
Immunizations: per Iowa schedule ⁷	●	●	●	●	●	●	●	●	●	●	●	●
Lab: Hemoglobinopathy/Metabolic Screen	● ⁸											
Hematocrit or Hemoglobin						→	→	→	→	→	→	→
Urinalysis												●
Lead Test						●		◆	◆ ⁹	◆	◆	◆
Cholesterol Screen									◆	◆	◆	◆
TB test ¹⁰						◆						→
Family Guidance: Injury Prevention	●	●	●	●	●	●	●	●	●	●	●	●
Child Car Seat Counseling	●	●	●	●	●	●	●	●	●	●	●	●
Tricycle Helmet Counseling									●	●	●	●
Sleep Position Counseling	●	●	●	●	●	●	●	●	●	●	●	●
Nutrition & Physical Activity Counseling	●	●	●	●	●	●	●	●	●	●	●	●
Violence Prevention	●	●	●	●	●	●	●	●	●	●	●	●
Child Development Guidance	●	●	●	●	●	●	●	●	●	●	●	●
	1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	2 yr	3 yr	4 yr	5 yr

Key: ● = to be performed
 ◆ = to be performed for high-risk children
 → = Range in which the task may be completed
 S = Subjective, by history
 O = Objective, by standard testing

³ The periodicity schedule was revised July 2009 by the Iowa Medicaid EPSDT program. http://www.idph.state.ia.us/hpcdp/epsdt_care_for_kids.asp
⁴ If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
⁵ Oral Health Assessment consists of dental history; recent concerns, pain or injury; visual inspection of hard and soft tissues of oral cavity; and dental referral based on risk assessment. http://www.idph.state.ia.us/hpcdp/oral_health.asp or toll-free: 866-528-4020.
⁶ Infants born in Iowa should have record of results from newborn hearing screening. <http://www.idph.state.ia.us/iaehdi/default.asp> or toll-free 800-383-3826.
⁷ Iowa Immunization program 1-800-831-6293.
⁸ All newborns should receive metabolic screening during neonatal period. www.idph.state.ia.us/genetics
⁹ Lead testing should be done at 12 & 24 months. Testing may be done at additional times for children determined at risk. Lead program 1-800-972-2026.
¹⁰ TB testing for only at-risk children, Iowa TB program 1-800-383-3826.