



Little Eagles Nest Learning Center School-Age Social Resume

Child's Name: _____

Social/Emotional Development

Is your Child involved in any extracurricular activities? Yes No

If yes, list: _____

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 afraid of anything? Yes No

Please comment: _____

How does your child show feelings?

Affection: _____ Fear: _____

Frustration: _____ Anger: _____

Excitement: _____

How does your child get along with other children?

How does your child get along with adults?

What activities does your child enjoy? _____

What activities does your child dislike? _____

How do you handle discipline in your home? _____

Self-Care

Does your child need any help with dressing? Yes No

If yes, please list: _____

Does your child need any help with toileting? Yes No

If yes, please identify: _____

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 _____

IOWA SCHOOL-AGE CARE - HEALTH STATUS - PARENT STATEMENT

Parent/Guardian please complete pages 1 and 2.

Child's name		Child's birthdate	Name of school
		Grade	School 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	Telephone #	Work #
		Pager #	Cellular #
		Home email	Work email
Where parent #2 works	Work address	Telephone #	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 parents/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 can not be reached.</p> <p>Parent/Guardian Signature: _____ Date _____</p> <p>Alternate emergency contact person's name: _____ Relationship to child: _____ Phone number: _____</p>			
Child's doctor's name	Doctor telephone #1	Hospital of choice	
Doctor's address	After hours telephone #	Does your child have health insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		Company _____	
		ID# _____	
Child's dentist's name	Dentist telephone #1	Does your child have dental insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		Company _____	
		ID# _____	
Dentist's address	After hours telephone #	<input type="checkbox"/> Please help us find health or dental insurance.	
		Call: 800-257-8563	
Other medical or dental specialist name	Telephone #	Specialist address:	
Type of specialty			
Mental Health care specialist	Telephone #	Specialist address:	

Child Name: _____

IOWA SCHOOL-AGE CARE - HEALTH STATUS - PARENT STATEMENT

Parent/Guardian complete this page

Please use a X in the box to statements that apply to your child.

Date of child's last physical exam: _____

Date of last dental appointment: _____

Growth

I am concerned about child's growth.

Appetite

I am concerned about child's eating habits.

Rest - My child

needs to rest after school.

Illness/Surgery/Injury - My child

Had a serious illness, surgery, or injury.

Please describe:

Physical Activity - My child

Must restrict physical activity or needs special equipment to be active. Please describe:

Play with friends - My child

- Plays well in groups with other children.
- Will play only with one or two other children.
- Prefers to play alone.
- Fights with other children.
- I am concerned about my child's play activity with other children.

School and Learning - My child

- Is doing well at school.
- Is having difficulty in some classes.
- Does not want to go to school.
- Frequently misses or is late for school.
- I am concerned about how my child is doing in school. Please describe:

Allergy - My child has allergies (list all allergies: food, medicine, fabric, inhalants, insects, animals, etc.):

Child has Epipen, Inhaler, or other emergency medication.
 Yes No

Parent Signature:
(required)

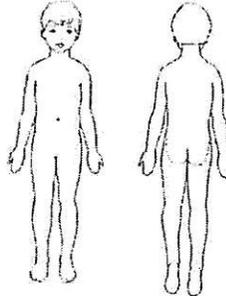
Date:

Child name: _____

Body Health - My child has problems with

Skin, hair, fingernails or toenails.

Describe skin marks, birthmarks, or scars. Show us where these skin marks are located using the drawing below.



- Eyes/vision, glasses or contact lenses
- Ears/hearing, hearing assistive aides or device, earache, tubes in ears
- Nose problems, nosebleeds
- Mouth, teeth, gums, tongue, sores in mouth or on lips, breaths through mouth
- Frequent sore throats or tonsillitis
- Breathing problems, asthma, cough
- Heart problems or heart murmur
- Stomach aches or upset stomach
- Trouble using toilet or wetting accidents
- Hard stools, constipation, diarrhea, watery stools
- Bones, muscles, movement, pain when moving
- Mobility, child uses assistive equipment

Please describe

- Nervous system, headaches, seizures, or nervous habits (like twitches or tics)
- Females – difficult monthly periods
- Other special needs. Please describe:

Medication¹ - My child takes medication.

Medication Name	Time Given	Reason for giving medication

Note to parents: **Certificate of Immunization**

School-owned and operated child care programs located on school property may file/store your child's Certificate of Immunization in the school office or in the school nurse's office. All other school-age child care programs must keep the Certificate of Immunization on-site at the child care facility.

¹ Parents: Please review the child care program's policies about the use of medication at child care.

IOWA SCHOOL-AGE CARE - HEALTH STATUS - PARENT STATEMENT

Health Professional's Physical Exam Findings*

Date of Physical Exam: _____

Height: _____ Weight: _____

Body Mass Index: _____

There are weight concerns and

Referral made to _____

Blood Pressure: _____

Laboratory Screening:

Blood Lead Level: _____ venous capillary (for child under age 6 yr)

Hgb. / Hct: _____

Urinalysis: _____

TB testing (high risk child only) _____

Sensory Screening

Vision: Right eye _____ Left eye _____

Hearing: Right ear _____ Left ear _____

Tympanometry: Right ear _____ Left ear _____

Exam Results (N = normal limits) otherwise describe

Skin: _____

HEENT: _____

Teeth/Oral health: _____

Date of Dentist Exam: _____ or None to date.
Dental Referral Made Today Yes No

Heart: _____

Lungs: _____

Stomach/Abdomen: _____

Genitalia: _____

Extremities, Joints, Muscles, Spine: _____

Neurological: _____

Other Notes: _____

Child Name: _____

Birthdate: _____ Age: _____

Vaccines given Today:

Vaccines entered into IRIS database. Yes No

DtaP/DTP/Td _____

HEP B _____

HIB _____

Influenza _____

MMR _____

Pneumococcal _____

Polio _____

Varicella _____

Other _____

Referrals made today:

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

Health provider authorizes the child to receive the following medications while at child care or school (Including over-the-counter and prescribed)

Medication Name	Dosage
<input type="checkbox"/> Fever/Pain reliever:	
<input type="checkbox"/> Sunscreen:	
<input type="checkbox"/> Cough medication:	
<input type="checkbox"/> Other - list all	

Health Provider Statement:

The child may fully participate with **NO** health-related restrictions.

The child has the following **health-related restrictions** to participation: (please specify)

Signature _____

Provider Type (circle) MD DO PA ARNP

Address: _____ Telephone: _____

* Iowa Child Care regulations require an annual parent statement about the child's health. Parents obtaining a physical exam are asked to have their family doctor or clinic use this form.

IOWA SCHOOL-AGE CARE - HEALTH STATUS - PARENT STATEMENT

Parents: A physical exam for school-age children enrolled in child care is not required every year. However, school-age children need to continue to receive health care to prevent illness and to identify potential health problems. The following guide will help you and your child prepare for a thorough exam with your family doctor or clinic. If you do not have a family doctor, please call the Healthy Families Line (1-800-369-2229) to locate a health care provider near you.

Iowa Recommendations for Preventive Health Care – School-Age Youth²

Health Provider Guide		5 yr.	6yr.	8 yr.	10 yr.	12 yr.	14 yr.	16 yr.
History:	Initial and Interval	●	●	●	●	●	●	●
Physical Exam		●	●	●	●	●	●	●
Measurement:	Height/ Weight/Body Mass Index	●	●	●	●	●	●	●
	Blood Pressure	●	●	●	●	●	●	●
Nutrition:	Assessment/ educate	●	●	●	●	●	●	●
Oral Health³	Assessment	●	●	●	●	●	●	●
Development and behavioral	Developmental surveillance	●	●	●	●	●	●	●
	Psychosocial/behavioral assessment	●	●	●	●	●	●	●
	Alcohol and drug use assessment	●	●	●	●	●	●	●
Mental Health / Mood:	Screening questionnaire	●	●	●	●	●	●	●
Sensory Screen:	Vision	●	●	●		●	●	
	(This screening may be completed at school or in child care)							
	Hearing	●				●		
Immunizations:	<i>per Iowa schedule</i> ⁴	●	●	●	●	●	●	●
Lab tests:	Hematocrit or Hemoglobin and (hemoglobinopathy for adolescents at risk)						← ● →	
	Urinalysis	●					← ● →	
	Lead Test ⁵	◆						
	Cholesterol Screen	◆						
	STD Screen and Genital or Pelvic Exam ⁶					◆	→	
	TB test ⁷	◆						→
Family Guidance:	Injury Prevention	●	●	●	●	●	●	●
	Seat Belt Use	●	●	●	●	●	●	●
	Bike Helmet Use	●	●	●	●	●	●	●
	Violence Prevention ⁸	●	●	●	●	●	●	●
	STD and Pregnancy Prevention males & females ⁹					●	●	●

Key: ● = To be performed | = Interview parent or child ◆ = for at risk children only Arrow indicates range which item may be completed

² The schedule of Preventive Health Care for children was revised July 2009 by the Iowa EPSDT Medicaid program for children.

³ Oral/dental health assessment consists of dental history; recent concerns; pain or injury; visual inspection of hard and soft tissues of oral cavity; dental referral based on risk assessment.

⁴ Immunization per schedule Iowa Immunization 1-800-831-6293.

⁵ Lead testing Iowa Lead Testing program 1-800-242-2026.

⁶ Sexually active youth should be screened.

⁷ TB testing only for at-risk children Iowa TB program 1-800-383-3826.

⁸ All families to receive domestic and youth violence prevention. CALL TEENLINE 1-800-443-8336 (operates 24/7).

⁹ All youth to have access to STD and pregnancy prevention services. CALL TEENLINE 1-800-443-8336.