PARENTAL EMERGENCY MEDICAL CONSENT

This form must be presented upon admission for treatment

This form allows parents and guardians to authorize the provision of emergency treatment for below 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 have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by the doctor or dentist listed below, or if unavailable, another licensed physician or dentist.

I agree to pay all costs and fees as secured or authorized under this consent.

CHILD'S NAME:	**BIRTH DATE:**	
PARENT(S)/GUARDIAN(S) WITH WHOM THE CHILD RESIDES		
1. NAME	RELATIONSHIP TO CHILD	
ADDRESS	EMPLOYER	
HOME NUMBER	CELL NUMBER	WORK NUMBER
2. NAME	RELATIONSHIP TO CHILD	
ADDRESS	EMPLOYER	
HOME NUMBER	CELL NUMBER	WORK NUMBER
EMERGENCY CONTACT PERSON(S)		
1. NAME	RELATIONSHIP TO CHILD	
HOME NUMBER	CELL NUMBER	WORK NUMBER
2. NAME	RELATIONSHIP TO CHILD	
HOME NUMBER	CELL NUMBER	WORK NUMBER
3. NAME	RELATIONSHIP TO CHILD	
HOME NUMBER	CELL NUMBER	WORK NUMBER

PERSONS AUTHORIZED TO PICK UP CHILD	**ADDRESS**	**PHONE NUMBER**
1.		
2.		
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?

Name	**Name**

PHYSICIAN NAME	**DENTIST NAME**
PHONE NUMBER	PHONE NUMBER
ADDRESS	ADDRESS
HOSPITAL PREFERENCE	
KNOWN ALLERGIES	DATE OF LAST TETANUS
PRESENT MEDICATION	
INSURANCE COMPANY	POLICY HOLDER ID

This consent will be in effect beginning (date) ______________________ **and be updated annually by the parent/legal guardian.**

SIGNATURE OF PARENT OR GUARDIAN	**DATE**	**SIGNATURE OF PARENT OR GUARDIAN**	**DATE**
UPDATE	**DATE**	**UPDATE**	**DATE**
UPDATE	**DATE**	**UPDATE**	**DATE**

INTAKE SHEET

I. Child's Identification Information

Name	Nickname:

Sex:	Birthdate	Name of school, if attending:

II. Family Information: Parents or Guardians

Name   Address   Place of Employment   Work Phone

____

____

_____ Single _____Married _____Divorced _____Separated _____Foster Parent

Names and ages of other children in the home:

______________________ _____ ______________________ _____
______________________ _____ ______________________ _____
______________________ _____ ______________________ _____

III. Emergency Contact

Name   Address   Place of Employment   Work Phone

____

____

IV. Play and Sociability

- How does your child get along with other children? ______________________
  ____
- His/Her usual playmates are _____girls _____boys _____older _____younger
- What is the usual size of your child's neighborhood playgroup?
- Previous group experience other than school: _____Preschool _____Playgroup _____Sunday School
- _____Other (Specify) ______________________

V. Personality and Emotional Development

- Is your child affectionate? ____________ To whom? ____________
- Does she/he accept new people easily? ____________ YES ____________ NO
- What are your child's fears? ______________________
- Is your child usually happy? ____________ YES ____________ NO
- What nervous habits does your child have? ______________________

VI. Discipline

INTAKE SHEET

- When you find it necessary to discipline your child, which parent usually does this and how? ____________________

VII. Infants and Toddlers

- Has your baby had any feeding problems? ________ YES ________ NO
  If yes, please explain ____________________
- Have you noticed any allergies or sensitivities to particular foods? ____________________
- Is your baby: Breast fed? ________ Bottle fed? ________
- What food is your baby eating now?
  Fruits ________ Juices ________
  Vegetables ________ Meats ________
  Cereals ________ Milk (Formula) ________
- Sleep habits during the day: ____________________
- Does your child have a "fussy" time? When? ____________________
- How do you handle this "fussy" time? ____________________
- Do you have special ways of helping your baby go to sleep? If yes, how. ____________________
- Does your child use a pacifier or suck thumb/fingers? ____________________
- Has toilet training been attempted? Yes No What is used at home? ____________________
- Is baby's skin highly sensitive? Yes No What is used at home? ____________________
- How does you child relate to strangers?
- Is your child frightened by anything? ____________________

VIII. Other Information: Please list some of your child's favorite:

Snacks & Drinks: ____________________

Games: ____________________

Other Activities: ____________________

Give any other information you believe will be helpful to us in understanding your child. ____________________

CHILD PHYSICAL EXAMINATION

Child's Full Name ______________________ **Date of Exam** ____________

Age ______ **Height** ________ **Weight** ______ **BP** ________ **P** ________

Vision: Eye Correction required ☐ Yes ☐ No ☐ Glasses ☐ Contact Lens

Hearing: ☐ Normal ☐ Abnormal ☐ Not Tested

EENT ______________
Teeth ______________
Neck ______________
Chest ______________
Lungs ______________
Heart ______________
Abd ______________
Hernia ______________
Extremities/Skin ______________
Posture/Spine ______________
Genitalia ______________
Rectum, Anus ______________
Neuromuscular ______________
Urinalysis ______________

If needed:

Hemoglobin or Hematocrit ______________
Sickle Cell screening ______________
Lead screening ______________
Tuberculin screening ______________
Development testing ______________
Other ______________

The child is under the care of a physician for the following medical condition(s):

____

____

Known allergies: ____

Additional health information: ____

____

____

The child is ______ is not _____ physically and/or emotionally able to participate in your program.

____
Signature of Physician or Designee

____
Date

PARENT: Please complete the following:

Diseases the child has had ____

____

Any special health needs ____

____

RELEASE AUTHORIZATIONS

Facility Name/Address ____

TRAVEL RELEASE

I/We do ______, do not ______, give consent for (name of child) ______________________________ to participate in field trips with the above named program. I/We do reserve the right to be notified before each field trip that involves travel out of town. I release the program of any liability unless negligence is proven.

Restrictions:

______________ ____

Date Signature of Parent or Legal Guardian

PHOTOGRAPHY/VIDEOTAPING RELEASE

I/We do ______, do not ______, give consent that the above named program may take photographs/videotapings of our child (name of child) ______________________________, and I/we consent that the program may use the photographs/videotapes of our child in promoting the purpose of the Center. We understand that no financial benefits from the use of the photographs/videotapes are obligated to be paid to us.

Restrictions:

______________ ____

Date Signature of Parent or Legal Guardian

SCHOOL-AGE TRAVEL TO AND FROM SCHOOL NOTIFICATION

I/We understand that my child will be transported with only one adult in a center-owned vehicle for the sole purpose of transporting children to and from school. My child will be transported to and from (name of school) ____.
This includes days in which there is early release/late starts at the school. I affirm that my child's participation in the transportation program is entirely my choice, with the understanding of risk or accidental injuries that may be involved in any transportation program in the Center.

______________ ____

Date Signature of Parent or Legal Guardian

Parent's/Guardian's Permission To Apply Sunscreen To Child

(Name of Child) ____

As the parent or guardian of the above child, I recognize that too much sunlight may increase my child's risk of getting skin cancer someday. Therefore, I give my permission for personnel at:

(Child Care Business) ____

to apply a sunscreen product of SPF-15 or higher to my child, as specified below, when he or she will be playing outside, especially during the months of March through October and between the daily times of 10 a.m. and 4 p.m. 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 have checked all applicable information regarding the type and use of sunscreen for my child:

☐ I do not know of any allergies my child has to sunscreen.

☐ ~~Staff may use the sunscreen of their choice following the directions or recommendations printed on the bottle~~

☐ I have provided the following brand/type of sunscreen for use on my child:

____

☐ My child is allergic to some sunscreens. Please use only the following brand(s) and type(s) of sunscreen:

____

____

☐ For medical or other reasons, please do not apply sunscreen to the following areas of my child's body:

____

Parent/Guardian full name (print): ____

Parent/Guardian signature: ______________________________ Date: ______________

Fee Agreement Contract

Parent or Guardian #1

I, ______________________________ (print name), have read, agree, and understand the terms and conditions written in Birdie's Nest Child Care Center's Handbook. I understand that if I do not follow the financial policies, that I will be liable for all tuition costs and fees. I also understand that my child could be released from Birdie's Nest Child Care Center's care if I do not adhere to these policies. I understand that tuition is due every Monday. I also understand that if tuition is not received by Tuesday, my child will not be allowed to return to the center until payment is made.

_________________________________(signature) ____/_____/_____ (date/month/year)

Fee Agreement Contract

Parent or Guardian #2

I, ______________________________ (print name), have read, agree, and understand the terms and conditions written in Birdie's Nest Child Care Center's Handbook. I understand that if I do not follow the financial policies, that I will be liable for all tuition costs and fees. I also understand that my child could be released from Birdie's Nest Child Care Center's care if I do not adhere to these policies. I understand that tuition is due every Monday. I also understand that if tuition is not received by Tuesday, my child will not be allowed to return to the center until payment is made.

_________________________________(signature) ____/_____/_____ (date/month/year)

Iowa Eligibility Application

FFY 16-17

Complete one application per household. School Year 2016-2017

Part 1. Check all applicable boxes:
☐ school meals
☐ special milk (restrictions apply)
☐ children in child care center
☐ Tier I home provider (HP)
☐ Head Start/Even Start
☐ children in child care home(HP)
Provider name:

Part 2. Check if any child is Homeless, Migrant, or a Runaway and call your child's school. ☐ Run away ☐ Migrant ☐ Homeless

Part 3. FIP or Food Assistance Eligible: Enter the FIP or Food Assistance Case Number for ANY household member as listed in the Notice of Decision. NOTE: Medicaid, Title XIX and EBT card numbers are not acceptable. Skip part 5.

Name of household member with Case Number ______ List Case Number ______

Part 4. Children enrolled. REQUIRED OF ALL APPLICANTS.

List name(s) of all enrolled child(ren) in your household.

Last Name	First Name	Middle Name or Initial	Check box for FOSTER child	Date of Birth	Grade	OPTIONAL: ETHNICITY	OPTIONAL: RACE	Name of School/Head Start/ Child Care Center/Home
1.			☐					
2.			☐					
3.			☐					
4.			☐					
5.			☐					

Part 5. Total Household Gross Income. DO NOT COMPLETE PART 5 IF YOU LISTED A FIP OR FOOD ASSISTANCE NUMBER IN PART 3. Report the gross income received by EACH household member one time in the correct column: weekly, every 2 weeks, twice a month or monthly. Gross income is the amount earned before taxes and other deductions, not take-home pay. Report all other monthly income received. Self-employed persons, see the worksheet on reverse side of this application.

List the names of everyone living in your household, including the children listed in Part 4. Attach a separate page if more space is needed. For FOSTER children, include only money available for child's personal use or child's own income.

Last Name	First Name	Age	Check if NO Income	Gross Income: Gross amount earned weekly	Gross amount earned every 2 weeks	Gross amount earned twice a month	Gross amount earned monthly	Other Monthly Payments or Income Received: Welfare, child support, alimony, adoption subsidies	Pension, retirement, social security, SSI, VA benefits	All other income
1.			☐							
2.			☐							
3.			☐							
4.			☐							
5.			☐							

Last four digits of my Social Security Number: X XX - X X - ___ ___ ___ ___ ☐ I do **not** have a Social Security Number.
If Part 5 is completed, the adult signing the form must provide the last 4 digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. **For further information refer to the Privacy Act Statement in the parent letter.**

Part 6. Certification and Signature. REQUIRED OF ALL APPLICANTS.
I certify (promise) that all information on this application is true and that all income is reported if required. I understand that I will receive benefits from Federal funds based on the information I give. I understand that officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal/milk benefits, and I may be prosecuted. Email of Adult Completing Form ______

Signature of Adult Completing Form ______ Printed Name of Adult Completing Form ______ Date Signed ______

Address of Adult Completing Form ______ Town ______ ZIP Code ______ Work Phone ______ Home Phone ______ Cell Phone ______

Part 7. DO NOT WRITE BELOW THIS LINE. FOR ADMINISTRATIVE USE ONLY.
Income conversion factors for annual income: weekly X 52; two weeks X 26; twice a month X 24; monthly X 12
Household Income: $ ______ ☐ Weekly ☐ Every 2 Weeks ☐ Twice Monthly ☐ Monthly ☐ Annually Household Size ______

Application Approved: ☐ Income ☐ Foster Child (free) ☐ FIP/Food Assistance
☐ Head Start DOCUMENTATION REQUIRED ☐ Homeless/Migrant/Runaway (Schools only)

Eligibility Determination: ☐ Free Meals ☐ Reduced Price Meals ☐ Free Milk
Application Denied: ☐ Incomplete ☐ Over income limits

CACFP HP ONLY:
☐ Tier 1 Area (Provider's own children)
☐ Tier 1 Income (All children)
☐ Tier 1 Child (Tier 2 mixed)

Determining Official Signature ______ Effective Date ______

Adult Completing Form______________________________

hawk-I /Medicaid Information Form: Read this information and sign if you do not want your name released to hawk-I or Medicaid.

If your children do not have health insurance, many families getting free and reduced price meals can also get free or low-cost health insurance for their children.

The law requires schools to share your free and reduced price meal eligibility information with Medicaid and *hawk-I*, the State's medical insurance program for children. Specifically, we will give them your child's name and your name and address. Medicaid and *hawk-I* can only use the information to identify children who may be eligible for free or low-cost health insurance and then to contact you. They are not allowed to use the information from your free and reduced meal application for any other purpose.

Childcare organizations may share this information at their option.

You are not required to allow us to share information from your children's free and reduced price meal application with Medicaid or the *hawk-I* program. It will not affect your children's eligibility for free and reduced price meals. If you do NOT want your information shared with Medicaid or *hawk-I*, you must tell us by completing the information below at the time you complete this eligibility application. If you want further information, you may call *hawk-I* at 1-800-257-8563.

I DO NOT want school/home sponsor/child care or Head Start center officials to share information from my free and reduced price meal application with Medicaid or *hawk-I*. Also, if you are already receiving Medicaid or *hawk-I*, please sign below. This will avoid another contact.

Child's Name: ______________________ School/Child Care/Head Start Center:______________

Child's Name: ______________________ School/Child Care/Head Start Center:______________

Child's Name: ______________________ School/Child Care/Head Start Center:______________

Parent/Guardian Name (Printed)____________________ **Signature**____________________ **Date**________

Self-Employment Income Worksheet: This worksheet will assist you in calculating the amount to report if you engage in farming, are self employed, or have income from other sources.

Persons who are engaged in farming or who operate other types of private businesses may experience variations in cash flow or monthly income throughout the year. These persons may use their income tax records from the preceding calendar year as a basis for applying for the free and reduced price meals. The income to be reported is income derived from the business venture less operating costs incurred in the generation of that income. Deductions for personal expenses such as medical expenses and other non-business deductions are not allowed in reducing gross business income.

If you have additional income from other kinds of employment, this income must be treated as separate and apart from the income generated from your business venture. USDA **DOES NOT** recognize income the same way as IRS. USDA does not permit a loss from a business venture to off-set earnings from wages or salary. Though your business may have suffered a net operational loss, for purposes of this application, it is not possible to have a negative income. The least self employed income possible is zero (no income). For example, if you operated a business at a net loss but hold another job where you received wages, your income for purposes of applying for free or reduced price meals would be the income from your wages only. The loss from the business cannot be deducted from the amount of the income earned in the other job.

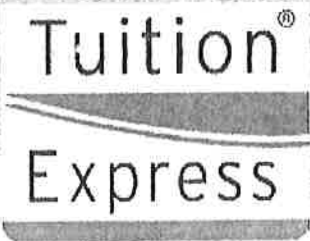
A prior year loss from farming or other private business operation cannot be used to reduce the current year net income for determining free and reduced price eligibility. Wages paid to a spouse or other family member in the operation of a farm or private business must be shown as household income in Part 5 of the application.

Income from private business operations is to be taken from your most recent U.S. Individual Income Tax Return Form 1040. Use the lines from the 1040 that are identified.

Line 12 Business income or (loss)	$ __________
Line 13 Capital gain or (loss)	$ __________
Line 14 Other gains or (losses)	$ __________
Line 17 - Rental real estate, royalties, partnerships, S corporations, trusts, etc.	$ __________
Line 18 Farm income or (loss)	$ __________
Total	$ __________
The least income possible is zero (a negative number cannot be reported) Total ÷ 12* =	__________

*Enter amount in the "All Other Income Last Month" column in Part 5 on the front of the Iowa Eligibility Application.

Optional Waiver Information (for Schools only)



We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) ______________________________ to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name ______________ Phone # ______________

Cardholder Address ______________ City ______________ State ______ Zip ______

Account Number ______________ Expiration Date ______________

Cardholder Signature ______________ Date ______________

SECTION B (Bank Account)

Your Name ______________ Phone # ______________

Address ______________ City ______________ State ______ Zip ______

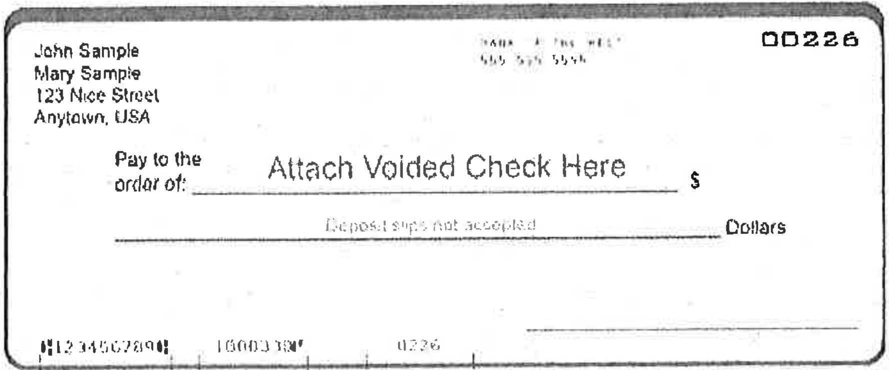
Bank or Credit Union Name ______________ Bank or Credit Union Address ______________ City ______________ State ______ Zip ______

Routing Transit Number (see sample below) ______________ Account Number (see sample below) ______________ ☐ Checking ☐ Savings

Authorized Signature ______________ Date ______________

For Official Use Only

Date Received
Employee Signature



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