The Comfort Zone

2623 Bruner Drive Ames, Iowa 50010

Phone: (515) 294-3333 Fax: (515) 294-7156

Email: **czone@iastate.edu**

Parent/Guardian Contact Information:

Child's name _____ Birthdate _____
Mother/guardian _____ (c) phone _____
Address _____ (h) phone _____
_____ Email _____
Father/guardian _____ (c) phone _____
Address _____ (h) phone _____
_____ Email _____
Siblings _____ Birthdate _____
_____ Birthdate _____
_____ Birthdate _____

Checklist for Pre-registration

❑Current physical
❑Immunization record
❑Income information (To participate in the sliding fee scale)

Parental Emergency Consent (Child's usual source of medical care)
Doctor phone _____ Address _____
Dentist phone _____ Address _____
Hospital _____ Phone _____
Address _____
Health Insurance subscriber name _____
Health Insurance carrier/ID number _____

Picture Release
I ❑do ❑do not give my consent for my child to be photographed for use by the Comfort Zone in newspapers or other media for the purpose of publicity or advertisement.
Initial:

Special conditions, disabilities, allergies or medical information for emergency situations

A. The Comfort Zone staff will be authorized to access emergency medical, dental and/or surgical care for my child.

B. Local EMT staff/first responder staff (ISU Dept. of Public Safety, City of Ames police and/or firefighters) have my consent to provide medical/dental/surgical treatment as necessary.

C. The Comfort Zone staff will arrange for emergency transportation to the hospital of my choice or the nearest emergency medical facility, if necessary.

D. I agree to pay all costs and fees contingent on any emergency medical, dental and/or surgical treatment for my child as secured or authorized under this consent.

Parent Handbook Agreement
I agree to abide by the policies as outlined in the Comfort Zone Parent Handbook. (Ask for a copy if you don't have one.)
Initial:

Pick-up Permission

The following people have my permission to pick up my child. I understand it is my responsibility to notify the Comfort Zone, in writing, of any changes. Photo ID required for any person picking up a child that is unknown to staff.

A. Name _____ B. Name _____
Phone _____ Phone _____
Relationship to child Relationship to child _____
Parent/Guardian _____ Date of signature _____
(signature of agreement and consent)

McFarland Clinic PC

CHILD'S NAME:_____

Birth date: _____

Date of Exam: _____

Height/Length: _____

Weight: _____

Head Circumference: _____

BP (start @ 3yr): _____

Allergies: _____

Known health and/or medical issues: _____

_____

LABS:

Hgb or Hct: _____ **Date tested:** _____

Blood lead level: _____ **Date tested:** _____

Sensory Screening

Vision: Right eye _____ **Left eye** _____

Hearing: Right ear _____ **Left ear** _____

Exam Results (***n = normal limits)***

HEENT: _____

Oral/Teeth: _____ **Dental referral?** ___**Yes** ___**No**

Neurological: _____

Skin & Lymph Nodes: _____

Heart: _____

Lungs: _____

Abdomen: _____

Genitalia: _____

Extremities, Joints, Muscles & Spine: _____

Immunizations: *Please attach a copy of the Iowa Department of Public Health Immunization Certificate (IRIS)*

Medication: Prescribed Medications must be in original labeled container and include written instructions on label. List any prescription medications:

_____

_____

_____

Non-Prescription Medications:

Sunscreen: May be applied with parental consent to children older than 6 months. Apply to exposed skin, except eyelids, 30 minutes before sun exposure, and every 2 hours while in the sun.

Diaper Cream: May be applied with parental request to children as needed until they are toilet trained. Diaper cream should be applied according to the instructions provided by the manufacturer.

Other non-prescription medications: to be given at daycare provider's discretion and parent/guardian's instructions.

Health Provider Assessment Statement:

Developmental screening:

☐ **normal** ☐ **abnormal**

Developmental referral made:

☐ **yes** ☐ **no**

_____ Child may participate in developmentally appropriate activities with ***NO*** health-related restrictions

_____ Child may participate in developmentally appropriate activities **with the following restrictions:**

P

_____

Physician Signature

Iowa Child Care Regulations require an admission physical exam report within the previous year and annually thereafter.

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 patient has a history of natural disease write "Immune to Varicella"			
Pneumococcal PCV/PPV			
Meningococcal MCV4/MPSV4			
Hepatitis A			
Rotavirus			
Human Papilloma Virus HPV			
Other			

April 2012

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; or 1 dose 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 1 dose received when the applicant is 15 months of age or older.
		Pneumococcal	4 doses; 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 if the applicant was born on or after September 15, 1997, unless the applicant has had a reliable history of natural disease.
	24 months 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 1 dose received when the applicant is 15 months of age or older. Hib vaccine is not indicated 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 12 months of age; or 2 doses if the applicant received 1 dose before 12 months of age or received 1 dose between 12 and 23 months of age; or 1 dose if no doses had been received prior to 24 months of age. **Pneumococcal vaccine is not indicated 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 if the applicant was born on or after September 15, 1997, 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[3, 4]	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; 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 before September 15, 2003; 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 on or after September 15, 2003.[2] DTaP is not indicated for persons 7 years of age and older, therefore, a tetanus-and diphtheria-containing vaccine should be used.
		Polio[6]	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; 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.[5]
		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 if the applicant was born on or after July 1, 1994.
		Varicella	1 dose received on or after 12 months of age if the applicant was born on or after September 15, 1997, but born 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 on or after September 15, 2003, unless the applicant has a reliable history of natural disease.[7]

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

[2] The 5th dose of DTaP is not necessary if the 4th dose was administered on or after 4 years of age.

[3] 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.

[4] 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.

[5] 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.

[6] If both OPV and IPV were administered as part of the series, a total of 4 doses are required, regardless of the applicant's current age.

[7] 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.