ENROLLMENT FORMS

LEARNING TREE PRESCHOOL

MCC Learning Tree Preschool and Child Care Center
152 Colorado Street
Muscatine, IA 52761
563-264-2088

Enrollment Date_____

STUDENT INFORMATION

Child's Name: Last_____First_____Middle_____

Child's Address_____

Birthdate_____Gender_____Home Phone_____

Ethnicity (circle one) H=Hispanic or Latino N=Non Hispanic or Latino

Race (circle one) A=Asian B=Black or African American I=American Indian or Alaska Native

P=Native Hawaiian or other Pacific Islander W=White

List other family members in the home:

Name_____ Age_____ Name_____ Age_____

Name_____ Age_____ Name_____ Age_____

Indicate days and times your child will be in the center:

Monday_____ Tuesday_____ Wednesday _____ Thursday_____ Friday_____

Anticipated meal participation: _____am snack _____lunch _____pm snack

Parent/Guardian Signature_____Date_____

PARENT/GUARDIAN INFORMATION

Mother's Name_____

Address (if different than child's)_____

Home Phone_____Cell Phone_____

Employer_____Work Phone_____

Father's Name_____

Address (if different than child's)_____

Home Phone_____Cell Phone_____

Employer_____Work Phone_____

If there is a separation, divorce or custody problem of which we should be aware, please explain:

_____

_____

AUTHORIZATION TO PICK UP

Persons authorized to pick up your child:

Name	Relationship to Child	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

NOTE: *Only* authorized persons will be allowed to pick up your child *unless prior arrangements have been made.* Identification will be required.

Parent/Guardian Signature_____Date_____

PHOTOGRAPH CONSENT

I give permission for pictures of my child to be taken while attending the Muscatine Community College Learning Tree Preschool and Child Care Center, and for these pictures to be used in publications.

Parent/Guardian Signature_____Date_____

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FIELD TRIP PERMISSION

(Child's Name)_____has my permission to participate in field trips planned and supervised by the personnel of MCC Learning Tree Preschool and Child Care Center.

Parent/Guardian Signature_____Date_____

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ENROLLMENT FEES

5 full days per week.....$130.00 weekly
2, 3 or 4 full days per week.....$30.00 daily
Half days (7:30am-1:00pm).....$25.00 daily
Mornings (8:00am-11:00am).....$15.00 daily
Student rate.....$3.00 per hour

I understand that I am responsible for payment for the enrollment option I have chosen, whether or not my child is in attendance, and that payments are due at least once every 2 weeks. I also understand that I am responsible for any fees not covered by my DHS or scholarship program (if applicable).

Parent/Guardian Signature_____Date_____

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PERMISSION FOR MEDICAL CARE IN PARENTAL ABSENCE
THIS FORM MUST BE PRESENTED ON ADMISSION FOR TREATMENT

In case of an emergency, every effort will be made to notify parent/guardian immediately.
This consent will be in effect as of (date)_____and continuing while child is enrolled in this facility.

Child's Full Name:_____Birthdate_____

In the event that my child, named above, may require emergency medical and/or surgical care when I am unable to be reached, I hereby give my consent for him/her to be treated at the NEAREST HOSPITAL OR MEDICAL FACILITY by ANY AVAILABLE PHYSICIAN. I agree to pay all costs and fees accrued by said medical care authorized under this consent.

In the event that my child, named above, may require emergency dental treatment when I am unable to be reached, I hereby give my consent for him/her to be treated at the NEAREST DENTAL FACILITY OR HOSPITAL by ANY AVAILABLE DENTIST OR PHYSICIAN. I agree to pay all costs and fees accrued by said dental care authorized under this consent.

Short medical history, problems or allergies including food allergies:_____

_____

Present medication: _____ Date of last tetanus (DPT) _____

Insurance: _____Hospital of preference_____

Child's Physician _____Phone _____
Address_____

Child's Dentist_____Phone_____
Address_____

Person(s) to be contacted in an emergency if parent/guardian is unavailable: **(Include on authorization to pick up)**

Name_____Home_____Cell_____Work_____

Name_____Home_____Cell_____Work_____

Print Parent/Guardian Name_____Home_____

Address_____Cell_____Work_____

Parent/Guardian Signature_____Date_____

School Entrance Physical Examination

Please Complete All Sections

_____ _____ has had a complete history and physical exam on _____

Student's Name | Birth Date | Month/Day/Year

Screening/Test Results	
Height:	
Weight:	
BMI:	
Blood Pressure:	
Pulse:	
Urinalysis:	
Lead: (Date/Result)	
Gross Dental:	
Other: (List/Result)	

Physical Exam	
General Appearance:	☐ Healthy ☐ Other _____
Nutrition:	☐ Good ☐ Fair ☐ Poor
E.E.N.T.:	☐ Normal ☐ Other _____
Heart & Lungs:	☐ Normal ☐ Other _____
Posture:	☐ Normal ☐ Other _____
Tonsils & Glands:	☐ Normal ☐ Other _____
Abdomen:	☐ Normal ☐ Other _____
Other: (List/Result)	

TB: In high-risk group? ☐ Yes ☐ No

Test	Date	Results

Physical Exam Comments:

Vision Screening? ☐ Yes ☐ No

☐ Without glasses		☐ With glasses	
Distance		Near	
R 20/	L 20/	R 20/	L 20/

Operations or injuries? (If yes, please list) ☐ Yes ☐ No

Auditory Screening? ☐ Yes ☐ No

Right:	☐ Pass	☐ Fail
Left:	☐ Pass	☐ Fail

Allergies? (If yes, please list) ☐ Yes ☐ No

Developmental Screening Results:

Personal/Social _____

Speech/Language _____

Fine Motor Skills _____

Gross Motor Skills _____

Please specify if student has a health condition which may require emergency action at school, e.g., seizures, asthma, allergies: _____

Please specify if student is on long-term medication: _____

This student may participate fully in the school program ___ yes ___ no If not, state reason _____

Signature of health care provider **Name and address of provider** **Phone Number**

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			
Varicella Chicken Pox If patient has a history of natural disease write "Immune to Varicella"			
Pneumococcal PCV/PPV			

	Vaccine	Date Given	Doctor / Clinic / Source
Meningococcal MCV4/MPSV4			
Hepatitis A			
Rotavirus			
Human Papilloma Virus HPV			
Other			

Licensed Child Care Requirements

4 through 5 months
- 1 dose D/T/P
- 1 dose Polio
- 1 dose Hib
- 1 dose Pneumococcal

6 through 11 months
- 2 doses D/T/P
- 2 doses Polio
- 2 doses Hib
- 2 doses Pneumococcal

12 through 18 months
- 3 doses D/T/P
- 2 doses Polio
- 2 doses Hib or 1 dose received at ≥ 15 months of age
- 3 doses Pneumococcal if received 1 or 2 doses < 12 months of age; or 2 doses if has not received any previous doses; or received 1 dose ≥ 12 months of age

19 through 23 months
- 4 doses D/T/P
- 3 doses Polio
- 3 doses Hib with the final dose in the series ≥ 12 months of age, or 1 dose received ≥ 15 months of age
- 1 dose Measles/Rubella ≥ 12 months of age
- 1 dose Varicella ≥ 12 months of age if born on or after September 15, 1997, or a reliable history of natural disease
- 4 doses Pneumococcal; or 3 doses if received 1 or 2 doses < 12 months of age; or 2 doses if not received any previous doses or has received no doses or has received 1 dose ≥ 12 months of age.

24 months and older
same requirements as the 19-23 months Except Pneumococcal.
4 doses Pneumococcal if received 3 doses < 12 months of age; or 3 doses if received 2 doses< 12 month of age; or 2 doses if received 1 dose < 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.

Elementary/Secondary School Requirements

4 years of age and older
- 5 doses Diphtheria/Tetanus/Pertussis with 1 dose received ≥ 4 years of age if born on or after September 15, 2003; or 4 doses, with 1 dose received ≥4 years of age if born after September 15, 2000, but before September 15, 2003; or 3 doses, with 1 dose received ≥ 4 years of age if born on or before September 15, 2000.
- 4 doses Polio with 1 dose received ≥ 4 years of age if born after September 15, 2003; or 3 doses, with 1 dose received ≥4 years of age if born on or before September 15, 2003.
- 2 doses Measles/Rubella; the first dose shall have been received ≥ 12 months of age; the second dose shall have been received ≥ 28 days after the first.
- 3 doses Hepatitis B if born on or after July 1, 1994.
- 2 doses Varicella ≥ 12 months of age if born on or after September 15, 2003; or 1 dose received ≥ 12 months of age if born on or after September 15, 1997, but born before September 15, 2003, unless the applicant has a reliable history of natural disease.

Learning Tree Daily Schedule

AM

7:30....Children arrive/free play
8:30....Homeroom centers
9:00....Clean-up/restrooms/show and tell and hand-washing
9:15....Snack
9:30....Small preschool groups
11:00...Morning dismissal/outdoor play or indoor free play
11:45...Clean-up/restrooms/hand-washing
12:00...Lunch

PM

12:30....Homeroom circle time/restrooms
12:40...Story time
1:00....Half day dismissal and naptime
3:00....Quiet play/ restrooms and hand-washing
3:30....Snack
3:45....Outdoor play and learning centers or indoor free play
5:00....Staff directed play
5:30....Center closes

Seasonal Sunscreen Application Permission Form

Child's Name: ______________________________ Date: _______________

Name of Medication (Sunscreen): ____
Reason for Medication (Sunscreen): Sunburn Protection

Please give the above medication (sunscreen) as directed below:

Amount to be given: Amount adequate to cover all exposed skin
At what time to be given: Before am outdoor play and pm outdoor play
Specified dates to be given at the center: Today thru end of season each day of attendance
Method of administration: Applied to all exposed skin

____I the undersigned, give **THE LEARNING TREE STAFF** authorization to administer the medication (sunscreen) as stated above.
____ I understand the importance of sunscreen in preventing sunburn, but do not wish to have sunscreen applied to my child.

Parent/Guardian Signature: __________________________ Date: _______________

Date	Medication	Amount	Time Given	Staff Initials

Child's name_____

Birthdate_____

Parent's name_____

Phone number_____

Days of attendance_____

Enrollment option_____

Start date_____

Registration fee paid_____