South Central Calhoun Schools
3-year-old Preschool
2018-2019

Program Facts:

Students must be three-years-old on or before September 15, 2018.

Students must be potty-trained.

Classes meet at both the SCC High School in Lake City and the SCC Elementary School in Rockwell City.

Students attend for 4 days a week. One section meets on Monday, Tuesday, Thursday, and Friday mornings from 8:00-11:00 (in either Lake City or Rockwell City). The other meets in the afternoons from 12:15-3:15 (Rockwell City) and 12:45-3:45 (Lake City).

Breakfast is optional. Only students with an IEP or Head Start funding are at school for lunch. The meal prices and guidelines for free/reduced meals are the same as for K-12 students. Students who eat breakfast and/or lunch at school must eat school meals. Bringing something from home is not permitted.

Tuition is $150/month. Financial assistance is available based on income guidelines. No tuition is charged for students with IEPs or with Head Start funding.

Transportation is provided for students who live outside the city limits of the attendance center *and* are on an existing route.

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Registration Checklist for 3-year-olds:

- ☐ Complete the "Pre-Enrollment" and "Registration and Emergency" forms and return them to either school building by April 13.
- ☐ Turn in a copy of your child's birth certificate.
- ☐ Turn in proof of a recent physical. The physical must have been within the last calendar year. Please ask your physician to use the form provided. *
- ☐ Turn in the "Diet Modification Request" form **only** if your child will be eating breakfast at school and has a known food allergy.
- ☐ Provide a valid certificate of immunization with up-to-date immunizations as required by Iowa schedule. *
- ☐ Complete the "Iowa Eligibility" form and provide income verification *if* you are interested in financial assistance for meals.
- ☐ You will receive a letter in June verifying your child's enrollment and assigned section.
- ☐ Attend school registration in August. Dates, times, and locations will be published.
- ☐ Scholarship information and application materials will be available in August.

* No child will be allowed to start preschool in the fall without a physical form and immunization record on file at the school. Please make your appointments accordingly.

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Pre-Enrollment Form

child's name: _____ DOB: _____

Is child currently enrolled in an Early Childhood program? Yes No If yes, where? _____

Do you have any concerns about your child's development? Yes ___ No ___

Do you want to apply for financial assistance for meals? Yes ___ No ___ for tuition? Yes ___ No ___

Is your household income less than $20,780 for a family of 3? 25,100 for a family of 4? Yes ___ No ___

Is your child toilet-trained? Yes ___ No ___

Before school, my child will be at ☐ home OR ☐ daycare at _____.

My child will get to school by _____.

I would like my child to attend at the
☐ Lake City location.
☐ Rockwell City location.
☐ no preference.

I would like my child to attend
☐ mornings.
☐ afternoons.
☐ no preference.

My child will leave school by _____.

He/she will go to _____.

Other factors I would like to have considered when assigning my child to a class: _____

_____.

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Registration & Emergency Information Form

Parent(s)/Guardian: _____

Please List All Students (full names) Oldest to Youngest:

1. _____ Grade: _____ Birth Date: _____ Race: _____
2. _____ Grade: _____ Birth Date: _____ Race: _____
3. _____ Grade: _____ Birth Date: _____ Race: _____
4. _____ Grade: _____ Birth Date: _____ Race: _____
5. _____ Grade: _____ Birth Date: _____ Race: _____

Home Phone #: _____ **Primary Language:** _____

Address: _____ **County:** _____

Email Address: _____

Father's Cell #: _____ Mother's Cell #: _____ (H.S. Only) Student's Cell #: _____

Father's Employer: _____ Mother's Employer: _____ Student's Cell #: _____

Father's Work #: _____ Mother's Work #: _____ Student's Cell #: _____

In Case of an Emergency and YOU cannot be reached - CONTACT: Name _____ Phone #_____

If the family has experienced a separation or divorce, please complete this section:

Provide the parent's name and address if the school is expected to mail school information to the parent.

Name: _____

Address: _____

City, State, Zip: _____

Has there been a court order that limits the contact this parent may have with the child, or that restricts parental rights? Yes __ No __

If yes, please provide a copy of the court document to be placed in student's cum. folder.

If there is another adult in your household who has your permission to act as a parent's authority for your child, please provide information.

Name: _____ Cell #: _____ Work #: _____

Signature of Parent/Guardian: _____ Date: _____

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

HEALTH PROFESSIONAL COMPLETE THIS PAGE[1]

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 Screening[2]**:**

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

Space is available on back page for detailed comments or instructions pertaining to enrollment at child care or preschool.

[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.

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
☐ Cough medication	
☐ Diaper crème:	
☐ Fever or Pain reliever:	
☐ Sunscreen:	
☐ 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*:

May use stamp

Signature _____

Circle the Provider Credential Type: MD DO PA ARNP

Address: Telephone:

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Iowa Department of Public Health
CERTIFICATE OF DENTAL SCREENING

This certificate is not valid unless all fields are complete.
RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Student Information (please print)

Student Last Name:	Student First Name:	Birth Date (M/D/YYYY):
Parent or Guardian Name:	Telephone (home or mobile):	
Street Address:	City:	County:
Name of Elementary or High School:	Grade Level:	Gender: ☐ Male ☐ Female

Screening Information (health care provider must complete this section)

Date of Dental Screening: _____

Treatment Needs (check ONE only based on screening results, prior to treatment services provided):

☐ **No Obvious Problems** – the child's hard and soft tissues appear to be visually healthy and there is no apparent reason for the child to be seen before the next routine dental checkup.

☐ **Requires Dental Care** – tooth decay[1] or a white spot lesion[2] is suspected in one or more teeth, or gum infection[3] is suspected.

☐ **Requires Urgent Dental Care** – obvious tooth decay[1] is present in one or more teeth, there is evidence of injury or severe infection, or the child is experiencing pain.

[1] Tooth decay: A visible cavity or hole in a tooth with brown or black coloration, or a retained root.
[2] White spot lesion: A demineralized area of a tooth, usually appearing as a chalky, white spot or white line near the gumline. A white spot lesion is considered an early indicator of tooth decay, especially in primary (baby) teeth.
[3] Gum infection: Gum (gingival) tissue is red, bleeding, or swollen.

Screening Provider (check ONE only):
☐ DDS/DMD ☐ RDH ☐ MD/DO ☐ PA ☐ RN/ARNP (High school screen must be provided by DDS/DMD or RDH)

Provider Name: (please print) _____ Phone: _____

Provider Business Address: _____

Signature and Credentials of Provider or Recorder*: _____ Date: _____

*Recorder: An authorized provider (DDS/DMD, RDH, MD/DO, PA, or RN/ARNP) may transfer information onto this form from another health document. The other health document should be attached to this form.

A screening does not replace an exam by a dentist.
Children should have a complete examination by a dentist at least once a year.
RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Iowa Department of Public Health • Oral Health Center
515-242-6363 • 866-528-4020 • www.idph.state.ia.us/ohds/OralHealth.aspx
A designee of the local board of health or Iowa Department of Public Health may review this certificate for survey purposes.