

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

Program Facts:

Students must be four-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 (M, T, Th, F).

Morning classes meet from 8:00-11:00. Afternoon classes meet from 12:15-3:15 in Rockwell City and 12:45-3:45 in Lake City.

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

There is no tuition. Students are funded either by Head Start or by the State.

Transportation is provided for students who live outside the city limits of the attendance center.

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Registration Checklist for 4-year-olds:

- Complete the enrollment form and return it to either school building by April 13.
- Turn in a copy of your child's birth certificate if he/she hasn't previously attended at SCC.
- Turn in proof of a recent physical if not already on file at school. The physical must have been within the last calendar year. Please ask your physician to use the form provided. *
- Turn in proof of a recent dental screening on the provided form. The screening must have been within the last calendar year, and the form must be turned in prior to the first day of school. *
- Provide a valid certificate of immunization with up-to-date immunizations as required by Iowa schedule. *
- Turn in the "Diet Modification Request" form **only** if your child will be eating breakfast or lunch at school and has a known food allergy.
- Complete the "Iowa Eligibility" form and provide income verification *if* you are interested in financial assistance for meals.
- Families of students who are funded by Head Start will have additional paperwork to complete with the Head Start Family Advocate.
- 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.

* No child will be allowed to start preschool in the fall without a physical form, dental 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: _____

Other Information

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

Do you have any concerns about your child's development? _____

Is your child potty trained? Yes ___ No ___

Is your gross annual income below \$25,100 (family of 4) ? yes no FIP/TANF

* Income information is necessary in order for the district to access funding for your child's attendance. Please be aware that this information may be shared with Head Start.

Do you want to apply for financial assistance for meals? 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 #: _____ (U.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: _____ Has there been a court order that limits the contact this parent may have with the child, or that restricts parental rights? Yes ___ No ___

Address: _____

City, State, Zip: _____ 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 PAGE¹

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 Screening²:

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.

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: _____

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 2006) 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 800-383-3828.

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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 (MM/YYYY):
Parent or Guardian Name:		Telephone (home or mobile):
Street Address:	City:	County:
Name of Elementary or High School:	Grade Level:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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 decay¹ or a white spot lesion² is suspected in one or more teeth, or gum infection³ is suspected.

Requires Urgent Dental Care – obvious tooth decay¹ 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 RNI/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 RNI/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.