Easter Seals Iowa Bob and Billie Ray Child Development Center
File Checklist

Name: ____ Date of Birth: _______________

Doctor: _____________________ Dentist: _____________________

Address: ____________________ Address: ____________________

Phone #: ____________________ Phone #: ____________________

____ Registration Form (page 2)

____ Emergency Information Sheet (page 3)

____ Authorization for Release of Child (page 3)

____ Emergency Care Release (page 4)

____ Communicable Disease Policy (page 5)

____ Parent Permission to Swim (page 6)

____ Parent Permission Signatures (page 7)

____ Web Cam Consent Form (page 8)

____ Childcare Enrollment Form (page 10)

____ CACFP Eligibility Application (pages 13-14)

____ Immunizations (page 15)

____ Physical (page 16) Date: __________

____ Professionally Prescribed Treatment (as needed)

Annual Update of File

Date: _______________ Date: _______________

Date: _______________ Date: _______________

Easter Seals Iowa Bob and Billie Ray Child Development Center
Registration Form

Child's Name: ___________________________________ Date of Birth: _______________

Allergies/Medications/Medical Concerns: ____

Parent/Guardian's Name: ____

Address: ___________________________________ City: _____________ State: _____ Zip: _____________

Home #: ____________________ Work #: ___________________ Cell #: _____________________

Place of Employment: _____________________________ Email Address: ____________________________

Parent/Guardian's Name: ____

Address: ___________________________________ City: _____________ State: _____ Zip: _____________

Home #: ____________________ Work #: ___________________ Cell #: _____________________

Place of Employment: _____________________________ Email Address: ____________________________

Identification
Four digit ID code: __________

Four digit password: __________

Easter Seals Iowa Bob and Billie Ray Child Development Center
Emergency Information

In case of an emergency please list 3 alternate contacts in the event that <u>parents cannot be reached</u>.

Emergency Contact #1

Name: ___________________________ Relationship: ____________________ Phone # ______________

Emergency Contact #2

Name: ___________________________ Relationship: ____________________ Phone # ______________

Emergency Contact #3

Name: ___________________________ Relationship: ____________________ Phone # ______________

My Child May Be Released To:

Name: ___________________________ Relationship: ____________________ Phone # ______________

Name: ___________________________ Relationship: ____________________ Phone # ______________

Name: ___________________________ Relationship: ____________________ Phone # ______________

My Child May NOT Be Released To:

Name: ___________________________

**If it is the child's biological parent you must file the appropriate paperwork in order for us to enforce custody arrangement.

Parent Signature: ____ Date: ___________________

Easter Seals Iowa Bob and Billie Ray Child Development Center
Emergency Care Release

In the event of an emergency or accident, I hereby give permission to the staff of the Easter Seals Iowa Bob and Billie Ray Child Development Center to transport my child____for emergency care to a clinic, hospital, or private doctor and secure treatment if needed. I am aware that any expenses incurred will be my responsibility.

Parent Signature: ____ Date:____________________

Doctor: ________________________________

Address: _______________________________

Phone #: _______________________________

Dentist: _______________________________

Address: ______________________________

Phone #: ______________________________

Hospital: ______________________________

Address: ______________________________

Phone #: ______________________________

Health Insurance Coverage

Name of Plan: __________________________

ID #: _________________________________

Name of Insured: _______________________

Easter Seals Iowa Bob and Billie Ray Child Development Center
Communicable Disease Policy

In order to help ensure that the health of all Easter Seals Bob and Billie Ray Child Development Center students/staff is safeguarded as much as possible, it is our policy that:

1. You immediately inform the school when it is known to you that your child has a communicable disease (i.e. measles, chicken pox, ect.)
2. Your child is not to return to school after having a communicable disease unless a written statement from your doctor is received stating that you child is in good health and free from communicable disease.
3. We inform all parents of Easter Seals Bob and Billie Ray Child Development Center students within 24 hours of notification that a student has a communicable disease specifying its nature so that you may call a physician for information. Communicable disease information is posted in the entryway.

Has your child been exposed to C.M.V. or any other contagious illness or virus that we need to be aware of?

Yes _________ No __________

I have read and agree to the above statement concerning the communicable disease policy.

Child's Name: ____________________________________

Parent Signature: _________________________________ Date: _________________

Easter Seals Iowa Bob and Billie Ray Child Development Center
Swimming Activity Program Child Approval Form

Child's Name: ______________________________________ Date of Birth: ______________________

Has this child ever been in water? Yes ____ No ____

Where? ________________

Does your child have a fear of water? Yes ____ No ____

Does your child swim in deep water? Yes ____ No ____

Has your child ever been in a swimming class? Yes ____ No ____

Is there anything else the lifeguard should know about you child?

____

Has your doctor approved of this activity for your child? Yes ____ No ____

(Ear drops will be administered if medically indicated and ordered by a physician)

I grant permission for my child to be involved in swimming activities.

Parent Signature: ____ Date: _____________________

Easter Seals Iowa Bob and Billie Ray Child Development Center
Parent Permission Signatures

Child's Name: _______________________________________ Expiration Date: ________________

Field Trips:

I hereby give my permission for my child to be included in any field trips away from the Easter Seals Iowa Bob and Billie Ray Child Development Center. I understand that I will be notified of these trips in advance.

Parent Signature: ____ Date: _________________

Pictures:

I hereby assign all rights to the film/photograph/videotape/sound recording made of my child by Easter Seals Iowa Bob and Billie Ray Child Development Center and authorize the use of same by Easter Seals, and those associated with it permission, for the purpose of illustration, publication, or broadcast in connection with the work of Easter Seals. I have read the foregoing release and authorization before affixing my signature and I verify that I fully understand the contents thereof.

Parent Signature: ____ Date: _________________

Assessment:

I give my permission for educational and/or therapeutic evaluations to be administered to my child during the program year.

Parent Signature: ____ Date: _________________

Easter Seals Iowa Bob and Billie Ray Child Development
Parent/Guardian Webcam Acknowledgement Statement

I acknowledge that I have been informed that the Easter Seals Iowa Bob and Billie Ray Child Development Center have equipped their classrooms with Webcam. I understand that by attending the Easter Seals Iowa Bob and Billie Ray Child Development Center, other families in my child's room will be able to view my child and their activities, but that no personal information about my child will be shared.

Parents/Guardians may subscribe to the Webcam viewing service to receive live video of their children in their classrooms throughout the day through any computer connected to the internet. The Easter Seals Iowa Bob and Billie Ray Child Development Center offers this extra service as a way to help families utilize our open door policy.

Web monitoring also allows management a less disruptive way of monitoring and supervising children and staff throughout the day, and a more accurate way to evaluate staff and maintain quality in the center. In no way is video monitoring used as a substitute for a teacher in our child:staff ratio-it is complimentary to these ratios.

Child's Name: ____

Parent/Guardian Signature: ____

Date: ______________________

My User Name Will Be: (8 or less characters, case sensitive) __________________

My Password Will Be: (8 or less characters, case sensitive) __________________

Easter Seals Iowa Bob and Billie Ray Child Development Center
Webcam Information Sheet

Why use webcams?

Easter Seals Iowa Bob and Billie Ray Child Development Center wanted to be able to provide parents a convenient way to visit our classrooms that support the open door policy. In addition to this, we wanted to be able to ive the director an opportunity to monitor all five classrooms. We will also be using the webcams for training opportunities to increase quality.

Is it safe?

Yes, it is a secure site that can only be accessed with a username and password. You will be asked to complete a permission slip and choose a password. The password will give you access to your child's classroom. The cameras have been strategically placed to avoid changing tables and restrooms.

Will there be a cost for parents who wish to utilize the webcams?

No, this is an added benefit.

Where are the cameras located?

There is one camera in each of the classrooms and one camera at each of the outside building doors.

Can I decline to have my child viewed on the webcam?

No, since the cameras are in the classrooms we cannot grant exclusion options.

What if I see something that upsets me?

We would ask that you handle your concern as you would handle any other concern. First speak with your child's teacher. If you are uncomfortable doing this or are not getting expected results, please visit with the director or assistant director. Finally if you still do not have resolution, you may file a grievance with the CEO Sherri Nielson who will make the final decision.

How can I assess the webcam?

The web address is https://esicdc.dyndns.org/webclient. You will then be asked for the user name and password that you noted on the webcam acknowledgement form.

Your child is enrolled for care in a child care center that participates in the Child and Adult Care Food Program (CACFP). By participating in this Program, the center is meeting Federal meal pattern requirements and receiving reimbursement to assist with food costs. The CACFP requires that parents provide CACFP enrollment information on an annual basis. This form will be placed in our files and treated as confidential information.

Revised 5/2015

Iowa Child and Adult Care Food Program
Child Care Enrollment Form

		Times of Care		Regular Days of Care							Meals Served During Care						Ethnicity/Race*	
Last Name, First Name	Date of Birth	Arrival	Departure	M	T	W	Th	F	S	S	B	AM Sn	Lu	PM Sn	D	E Sn	Ethnicity	Race

*Ethnicity (Select one and enter in the chart above): H=Hispanic or Latino or N=Not Hispanic or Latino
Race (Select one or more and enter in the chart above): W=White, B=Black or African American, I=American Indian or Alaska Native, A=Asian, and P=Pacific Islander
This information is requested by the Federal Government in order to monitor compliance with civil rights law. You are not required to furnish this information, but are encouraged to do so. The law requires that a program recipient may neither discriminate on the basis of this information nor on whether you choose to furnish it. However, if you choose not to furnish it, under Federal regulations, this program representative is required to note race/ethnicity on the basis of visual observation or surname.

Infants only (0 to 12 months): ☐ I am not enrolling an infant (skip this section)

As a participant in a USDA Child Nutrition Program, our center offers meals to children of all ages. Infant feeding is based on current nutrition guidelines. Infant foods are appropriate for the age and developmental readiness of your infant. Please select (X) your choice(s) of the following options that will fulfill your infant's food needs.

☐ I will provide breast milk for my infant. Center formula may be used to supplement feedings if necessary: ☐ Yes ☐ No

☐ I will provide infant formula for my infant. Name of formula: ____________

☐ I accept the center's formula for my infant. Name of formula: ____________

☐ I will provide a statement from a medical authority for non-reimbursable formula. Name of formula: ____________

☐ I accept the center's solid foods (appropriately textured) to be served to my infant as s/he is ready for them, and after I have discussed it with the caregiver.

☐ I will provide solid foods for my infant*. The center may supplement with additional solid foods when my infant needs them: ☐ Yes ☐ No

*The center must provide at least one component in order to claim the meal. DHS licensed centers are required to follow CACFP infant meal pattern requirements regardless of who supplies the food. Your center can provide a copy of the CACFP infant meal pattern and a list of reimbursable foods upon request.

Parent Signature________________________ Date:__________

Parent Signature________________________ Date:__________ (Make any needed changes above, sign and date)

Parent Signature________________________ Date:__________ (Make any needed changes above, sign and date)

USDA is an equal opportunity provider and employer.

This form is available in Spanish in "Download Forms" on the website where claims are submitted

Iowa CACFP Child Care Center Parent/Guardian Letter - Non-pricing (front) Rev. 7/15

Purpose: The attached Iowa Eligibility Application is used to determine eligibility for free and reduced price meal reimbursement. The instructions for completion are on the back of this letter.
Instructions to centers: Choose Form A if you do not have a separate charge for meals. Copy this letter (front and back) and staple to each Iowa Eligibility Application that is distributed to families of enrolled participants.

Dear Parent or Guardian:

This center participates in the Child and Adult Care Food Program (CACFP) administered by the United States Department of Agriculture (USDA). Participants are not charged separately for meals. However, by participating in this Program, the center receives partial reimbursement for nutritious meals served to children. The amount of reimbursement the center receives is determined by the information you provide. Providing information can help your center purchase nutritious food. Higher reimbursement will be given to the center for meals served to enrolled children from families whose income is at or below the level shown in the chart below. Please read the instructions on the back, complete, sign and return the attached income application as soon as possible. An application that does not contain all required information cannot be used by the center. If required information is missing, free or reduced-price meal benefits will be denied. Call your center if you need help with the form. The information reported on this form will be filed and treated as confidential.

A foster child who is the legal responsibility of a welfare agency or court may be certified as eligible for free meals regardless of your household income. See instructions on the back for more information.

If you do not qualify now to receive free or reduced price meals, you may apply for benefits at any time during the year. If you have a decrease in household income, have an increase in family size, or have enrolled children that become eligible for food assistance or FIP, you may fill out an application at that time.

Income Eligibility Guidelines for Reduced Price Meals
Effective 7-1-2015 to 6-30-2016

Household Size	Reduced Price Meals				
	Yearly	Monthly	Twice per Month	Every Two Weeks	Weekly
1	21,775	1,815	908	838	419
2	29,471	2,456	1,228	1,134	567
3	37,167	3,098	1,549	1,430	715
4	44,863	3,739	1,870	1,726	863
5	52,559	4,380	2,190	2,022	1,011
6	60,255	5,022	2,511	2,318	1,159
7	67,951	5,663	2,832	2,614	1,307
8	75,647	6,304	3,152	2,910	1,455
For each additional family member add:	+7,696	+642	+321	+296	+148

Privacy Act Statement: This explains how we will use the information you give us.

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. The last four digits of the social security number of the adult household member who signs the application must be listed. The social security information is not required when you apply on behalf of a foster child or if you list a Food Assistance number, or Family Investment Program number, or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the CACFP. We may share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

Non-discrimination Statements: Explain what to do if you believe you have been treated unfairly.

USDA Non-Discrimination Statement: The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866)632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax 202-690-7442 or email at program.intake@usda.gov. *Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339; or 800-845-6136 (Spanish).* USDA is an equal opportunity provider and employer.

Iowa Nondiscrimination Notice: "It is the policy of this CNP provider not to discriminate on the basis of race, creed, color, sex, sexual orientation, gender identity, national origin, disability, age, or religion in its programs, activities, or employment practices as required by the Iowa Code section 216.6, 216.7, and 216.9. If you have questions or grievances related to compliance with this policy by this CNP Provider, please contact the Iowa Civil Rights Commission, Grimes State Office Building, 400 E. 14th St., Des Moines, IA 50319-1004; phone number 515-281-4121, 800-457-4416; website: https://icrc.iowa.gov/."

Instructions for Completing Iowa Eligibility Application

Complete both sides of an application for each household.

All applicants should complete Part 1. This application may be used to apply for benefits in school meals or milk programs, child care centers and home based care for children. Check all boxes that apply to your family. You may make copies of a completed application for each program in which your child participates.

FIP OR FOOD ASSISTANCE HOUSEHOLD MEMBER, **including child(ren) in Head Start or Even Start**, follow these instructions.
Part 3. List one FIP or Food Assistance **Case Number** per household in the area provided. **Use the Case Number listed in the DHS Notice of Decision**. Eligibility based on Head Start or Even Start is available only if your child is enrolled in Head Start and documentation from the Head Start agency is provided. **NOTE: Medicaid, Title XIX and EBT card numbers are not acceptable.**
Part 4. List the name, date of birth, grade (if applicable), name of school/Head Start/child care center attended for each child in your household. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your child's ethnic and racial status if you do not complete this section.
Part 5. Skip this section.
Part 6. Read the certification and complete this section.

HOMELESS, MIGRANT OR RUNAWAY, **follow these instructions.**
Part 2. For children attending school, check if any child is Homeless, Migrant, or a Runaway and call your child's school.
Part 4. List the name, date of birth, grade (if applicable), name of school/Head Start/child care center attended for each child in your household. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your child's ethnic and racial status if you do not complete this section.
Part 5. Skip this section.
Part 6. Read the certification and complete this section.

FOSTER CHILD IN HOUSEHOLD, follow these instructions. A foster child is a child who is living with a household but who remains the legal responsibility of the welfare agency or court. Foster children can be included as household members or included on a separate application.
Part 4. List the child's name, date of birth, grade (if applicable), name of school/Head Start/child care center attended. Check the box for foster child. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your foster child's ethnic and racial status if you do not fill this section.
Part 5. Complete this section only if the foster child receives money for personal use or has other regular personal income. If the foster child has no income, check the box indicating no income. DO NOT include the stipend received by the foster family to provide care to the foster child.
Part 6. Read the certification and complete this section.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions for reporting income.
Part 4. List the name, date of birth, grade (if applicable), name of school/Head Start/child care center/home attended for each child in your household. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of each child's ethnic and racial status if you do not complete this section.
Part 5. Follow these instructions to report total household income from last month.

- **Name:** List the last and first names of **each** person living in your household, related or not (such as grandparents, other relatives, or friends); include yourself and all children living with you. The household decides whether to include the foster child on their household application with non-foster children. Attach another sheet of paper if needed.
- **Age:** List the age of each household member.
- **Check if No Income:** Put a mark in the box if the household member **does not** have an income.
- **Gross Income last month and how it was received:** Report the amount of income received in the appropriate Gross Income column (weekly, every 2 weeks, twice monthly, **or** monthly). List the **gross income** each person earned from work. This is not the same as take-home pay. **Gross income is the amount earned before taxes and other deductions.** The amount should be listed on your pay stub, or your boss can tell you. If you have a household member for whom last month's income was higher or lower than usual, list that person's expected average income. If the household includes the foster child, they must report any personal income received by the foster child on the foster parent's household application.
- **Other Monthly Payments or Income:** Money is reported in this section if it is regularly received. List the amount each person received last month from welfare, child support, alimony, adoption subsidies, pensions, retirement, Social Security, Supplemental Security Income (SSI), and Veteran's benefits (VA benefits). In the **All Other Income** column, include Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, cash withdrawn from savings, investments or trusts, interest and **ANY OTHER INCOME**. Use the Self-Employment Income Worksheet on the back of the application to calculate net income for self-owned businesses, farm, or rental income and report in the **All Other Income** column. **Do not report**: Scholarships, educational benefits, lump sum payments, combat pay, Deployment Extension Incentive Pay (DEIP) or children's incidental income from occasional activities such as babysitting, shoveling snow, or cutting grass. If you are in the Military Housing Privatization Initiative or get combat pay do not include these allowances.
- **Social Security Number:** If the application is being made on the basis of income, 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. If you do not provide your Social Security information or mark the box, your application cannot be processed.

Part 6. Read the certification and complete this section.

Iowa Eligibility Application

Complete one application per household. School Year 2015-2016

FFY 15-16

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)

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

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

Determining Official Signature ____________ **Effective Date** ____________

Confirming Official Signature (Schools only) ____________ **Date** ____

Follow-Up Official Signature (Schools only) ____________ **Date** ____

Name of 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 held 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)

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 applicant 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

<u>4 through 5 months</u>
1 dose Diphtheria/Tetanus/Pertussis
1 dose Polio
1 dose Hib
1 dose Pneumococcal

<u>6 through 11 months</u>
2 doses Diphtheria/Tetanus/Pertussis
2 doses Polio
2 doses Hib
2 doses Pneumococcal

<u>12 through 18 months</u>
3 doses Diphtheria/Tetanus/Pertussis
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 received 1 dose ≥ 12 months of age or has not received this vaccine before.

<u>19 through 23 months</u>
4 doses Diphtheria/Tetanus/Pertussis
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 received 1 dose ≥ 12 months of age or has not received this vaccine before.

<u>24 months and older</u>
Same requirements as the 19-23 months except **4 doses Pneumococcal** if received 3 doses < 12 months of age; or 3 doses if received 2 doses < 12 months 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

<u>4 years of age and older</u>
5 doses Diphtheria/Tetanus/Pertussis with at least 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 on or 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 before September 15, 2003, unless the applicant has a reliable history of natural disease.

Infant, Toddler, Preschool Age – Child Health Exam Form

PARENTS/GUARDIAN COMPLETE PAGES 1 and 2 – **Child Information**

Child's name	Child's birthdate	Name of center, provider, or preschool Telephone #
Parent 1 name	Parent 2 name	
Child home address #1		Telephone # 1
Child home address #2		Telephone #2
Where parent # 1 works	Work address	Home phone # Work # Pager # Cellular # Home email Work email
Where parent # 2 works	Work address	Home phone # Work # Pager # Cellular # Home email Work email

In the event of an emergency, the child care provider is authorized to obtain EMERGENCY MEDICAL or DENTAL CARE even if the child care center is unable to immediately make contact with the parent/guardian. ☐ **YES** ☐ **NO**

During an emergency the child care provider is authorized to contact the following person when parent or guardian cannot be reached.

Parent/Guardian Signature: ______________________________ Date ______________

Alternate emergency contact person's name:______________________ Phone number:

Relationship to child: Cellular number:

Child's doctor's name	Doctor telephone # 1	Hospital choice
Doctor's address	After hours telephone #	Does child have health insurance? ☐Yes, Company ____________ **ID #**
Child's dentist's name	Dentist Telephone # 1	Does child have dental insurance? ☐Yes, Company ____________ **ID#**
Dentist's Address	After hours telephone #	☐ **NO, we do not have health insurance.** ☐ **NO, we do not have dental insurance.**
Other health care specialist name Type of specialty	Telephone #	☐ **Please help us find health or dental insurance.**

Child Name:

PARENTS COMPLETE THIS PAGE

Parents: Tell us about your child's health. Place an **X** in the box ☒ if the sentence applies to your child. Check *all* that apply to your child. This will help your doctor plan your child's physical exam.

Growth

☐ I am concerned about my child's growth.

Appetite

☐ I am concerned about my child's eating / feeding habits or appetite.

Rest -

☐ I am concerned about the amount of sleep my child needs.

Illness/Surgery/Injury - My child

☐ had a serious illness, injury, or surgery.

Please describe.

Physical Activity - My child

☐ must restrict physical activity.

Please describe.

Development and Learning

☐ I am concerned about my child's behavior, development, or learning.

Please describe:

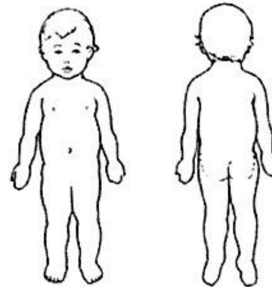
☐ **Medication** - My child takes medication.
List the name, time medication taken, and the reason medication prescribed.

Child's Name: ____________________

Body Health - My child has problems with

☐ Skin, birthmarks, Mongolian spots, hair, fingernails or toenails.

Map and describe color/shape of skin markings birthmarks, scars, moles



☐ Eyes \ vision, glasses
☐ Ears \ hearing, hearing aides or device, earaches, tubes in ears
☐ Nose problems, nosebleeds, runny nose
☐ Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring
☐ Frequent sore throats or tonsillitis
☐ Breathing problems, asthma, cough, croup
☐ Heart, heart murmur
☐ Stomach aches, upset stomach, colic, spitting up
☐ Using toilet, toilet training, urinating
☐ Bones, muscles, movement, pain with moving
☐ Mobility, uses assistive equipment
☐ Nervous system, headaches, seizures, or nervous habits (like twitches)
☐ Needs special equipment. *Please describe*:

☐ **Allergies**-My child has allergies (medicine, food, dust, mold, pollen, insects, animals, etc.).

Please describe:

Parent questions or comments for the health care provider:

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.

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 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.

Health Care Provider comments or instructions: **Child's name:** ____________________

Iowa Health Care Provider -- Guide to Iowa Recommendations for Preventive Pediatric Health Care[3]

Health Provider's Guide		AGE[4]											
		1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	2 yr	3 yr	4 yr	5 yr
History:	Initial and Interval	●	●	●	●	●	●	●	●	●	●	●	●
Physical Exam		●	●	●	●	●	●	●	●	●	●	●	●
Measurement:	Height/ Weight	●	●	●	●	●	●	●	●	●	●	●	●
	Head Circumference	●	●	●	●	●	●	●	●	●			
	Blood Pressure	Risk Assessment									●	●	●
Nutrition	Assess/Educate	●	●	●	●	●	●	●	●	●	●	●	●
Oral Health Assessment[5]		●	●	●	●	●	●	●	●	●	●	●	●
Development and Behavioral Assessment		●	●	●	●	●	●	●	●	●	●	●	●
	Developmental Screening					●			●		●		
	Autism Screening								●	●			
	Developmental Surveillance	●	●	●	●		●	●		●		●	●
	Psychosocial/behavioral Assessment	●	●	●	●	●	●	●	●	●	●	●	●
Sensory Screen:	Vision	S	S	S	S	S	S	S	S	S	O	O	O
	Hearing[6]	S	S	S	S	S	S	S	S	S	S	O	O
Immunizations:	*per Iowa schedule*[7]	●	●	●	●	●	●	●	●	●	●	●	●
Lab:	Hemaglobinopathy/Metabolic Screen	●[8]											
	Hematocrit or Hemoglobin					● →	→	◆ →	→	→	→	→	→
	Urinalysis												●
	Lead Test						●		◆	●[9]	◆	◆	◆
	Cholesterol Screen									◆ →	→	→	→
	TB test[10]						◆	→	→	→	→	→	→
Family Guidance:	Injury Prevention	●	●	●	●	●	●	●	●	●	●	●	●
	Child Car Seat Counseling	●	●	●	●	●	●	●	●	●	●	●	●
	Tricycle Helmet Counseling									●	●	●	●
	Sleep Position Counseling	●	●	●	●	●	●						
	Nutrition & Physical Activity Counseling	●	●	●	●	●	●	●	●	●	●	●	●
	Violence Prevention	●	●	●	●	●	●	●	●	●	●	●	●
	Child Development Guidance	●	●	●	●	●	●	●	●	●	●	●	●
		1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	2 yr	3 yr	4 yr	5 yr

Key: ● = to be performed
◆ = to be performed for high-risk children
→ = Range in which the task may be completed

S = Subjective, by history
O = Objective, by standard testing

[3] The periodicity schedule was revised July 2009 by the Iowa Medicaid EPSDT program. http://www.idph.state.ia.us/hpcdp/epsdt_care_for_kids.asp

[4] If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

[5] Oral Health Assessment consists of dental history; recent concerns, pain or injury; visual inspection of hard and soft tissues of oral cavity; and dental referral based on risk assessment. http://www.idph.state.ia.us/hpcdp/oral_health.asp or toll-free: 866-528-4020.

[6] Infants born in Iowa should have record of results from newborn hearing screening. http://www.idph.state.ia.us/iaehdi/default.asp or toll-free 800-383-3826.

[7] Iowa Immunization program 1-800-831-6293.

[8] All newborns should receive metabolic screening during neonatal period. www.idph.state.ia.us/genetics

[9] Lead testing should be done at 12 & 24 months. Testing may be done at additional times for children determined at risk. Lead program 1-800-972-2026.

[10] TB testing for only at-risk children, Iowa TB program 1-800-383-3826.