Saydel
EAGLE'S NEST

Saydel Community School District

Registration & Emergency Form

All information must be completed.

Last Name	First Name	Middle Initial

Birthdate	School (circle one) _____Woodside Middle School _____Cornell Elementary School	Grade Level

PLEASE CHOOSE ONE

____ AM Only $35 per week per child
____ PM Only $35 per week per child
____ AM & PM Only $50 per child

____Wednesday AM Only $5 per child
____Wednesday AM and Every PM

____Summer Care $100 per week per child & $80 per week per sibling

PARENT/LEGAL GUARDIAN INFORMATION

Name (mother):	Mother's primary phone:	Mother's employer:
Mother's home address: (include city)	Mother's alternate phone:	Mother's email:
Name (father):	Father's primary phone:	Father's employer:
Father's home address: (include city)	Father's alternate phone:	Father's email:

EMERGENCY CONTACT INFORMATION

Child's doctor's name:	Doctor's clinic name:	Doctor phone:
Child's dentist's name:	Child's dentist's address:	Child's dentist's phone:
Hospital preference:	Hospital preference address:	Hospital preference phone:
Other medical specialist's name:	Type of specialty:	Specialist's address & phone:

INSURANCE INFORMATION:

____ Yes, my child has HEALTH insurance.

Insurance provider:_____ Insurance ID #_____

____ No, my child does not have HEALTH insurance.

____ Please help us find HEALTH insurance.

____ Yes, my child has dental insurance.

Insurance provider:_____ Insurance ID #_____

____ No, my child does not have DENTAL insurance.

____ Please help us find DENTAL insurance.

EMERGENCY INFORMATION

In the event that my child may require emergency medical, dental or surgical care while I am unable to be reached, I hereby give my consent to medical, dental, or surgical treatment to the medical providers listed below. I agree to pay all costs and fees contingent on emergency care or treatment for my child as secured or authorized under this consent.

Parent/Guardian Signature_____ Date_____

EMERGENCY CONTACTS & AUTHORIZED PICK-UP

I hereby give consent for my child to leave Eagle's Nest with the emergency contacts/authorized pick-up people listed below. It is the responsibility of a parent/legal guardian to notify the program in writing with any changes.

Emergency contact's name:	Relationship to student:	Primary phone:
1.		
2.		
3.		
4.		

THE FOLLOWING PEOPLE ARE NOT AUTHORIZED TO PICK UP MY CHILD:
Please list name and relationship to child.

1. _____

2. _____

3. _____

4. _____

5. _____

I will provide copies of legal custody/visitation documents, if applicable.

____Yes

____No

Please add the following emails to receive Eagle's Nest group emergency messages:

1. _____

2. _____

3. _____

4. _____

5. _____

PARENT/LEGAL GUARDIAN HEALTH & SAFETY CONSENT

__Yes __No	My child has up to date physical and immunization records on file with Saydel Community School District.
__Yes __No	My child has medical concerns/allergies. I will provide specific information below.
__Yes __No	If my child requires medication during Eagle's Nest, I will fill out the Medication Release form and I will bring the medication in the original container.
__Yes __No	My child has permission to participate on field trips and to be transported by Durham Bus Service.
__Yes __No	I give consent for my child's picture/audio/video to be taken during Eagle's Nest and to be used in school or city publications.
__Yes __No	Eagle's Nest staff has my permission to apply sunscreen and bug spray to my child, as needed. I understand I am responsible for providing both sunscreen and bug spray for my child.
__Yes __No	**WAIVER OF RISK:** I understand that despite careful and proper preparation, there is still a risk of injury when participating in activities. In the case of an accident or injury sustained during an activity, I will release the school and staff from responsibility for such accident or injury. In addition, I release the school and staff from actions, damages or liabilities that may occur due to treatment of any sickness or injury.

Parent/Guardian Signature_____ Date_____

PARENT/LEGAL GUARDIAN

Please give a brief description of any medical concerns or allergies your child has:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medication Release Form

Name of Student: _____

Medication: _____

Dosage: _____ (Amount and times during the day)

Special Instructions *(including any special storage requirements and noting any side effect(s) of which Eagle's Nest should be aware).*

_____

Reason for the medication: _____

Name of Physician: _____

Date: _____

PARENTAL CONSENT AND WAIVER

I hereby give my permission for my child _____ in the _____ grade at Saydel Community School District to take the above prescribed medication during Eagle's Nest.

Notice: No prescription medication may be used or possessed at school/Eagle's Nest unless this form is completed. All medicine brought into the school/Eagle's Nest must be kept in a locked container by the Eagle's Nest Supervisor and must be stored in the original container, appropriately labeled by the pharmacy or physician.

WAIVER OF LIABILITY

I understand that Saydel Eagle's Nest will administer only the prescribed medication mentioned above. I hereby waive any and all claims against the school, and agree to hold the school harmless from any and all liability, which may arise in connection with my child's use of the medication.

Parent/Guardian Signature_____ Date_____

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

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.

Diet Modification Request Form

Description: The United States Department of Agriculture (USDA) reimburses home day care providers, child and adult care centers, summer food service sponsors, schools, residential child care institutions, preschools, and Head Start for meals served to participants that meet USDA requirements. The Child Nutrition Program participating home provider or organization is listed below for meals served in their program. If a participant needs to avoid specific foods for a medical reason, a prescribing licensed medical professional must document the diet modifications and sign this form.

Please complete this form and return to your organization or provider:_____
(Name of home provider or organization)

Participant's Name: _____ Birth Date: _____ Grade:_____

Parent/Guardian's Name: _____

1) Does the participant have a disability? ❑ No ❑ Yes (identify)	
If yes, describe the major life activity or functions affected by the disability (see link for definitions of disability http://www.eeoc.gov/laws/statutes/adaaa_info.cfm)	
If yes, explain why the disability restricts the participant's diet:	
If no, identify the medical condition that does not rise to the level of a disability:	
2) Food(s) or Formula to Omit:	**Food(s) or Formula to Substitute:**
3) Texture modifications:	
Infants must receive iron-fortified infant formula or breast milk unless an allergy/exception statement is on file.	
The back of this form includes additional descriptions ❑ No ❑ Yes	

Licensed prescribing medical professional*: _____
Name (Print or Type) Title

*In Iowa licensed prescribing medical professionals include Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Physician's Assistant (PA), or Advanced Registered Nurse Practitioner (ARNP).

_____ _____
Signature of medical professional Date

If the participant has a disability, the provider must offer to supply the food substitutions unless doing so would be a documented financial hardship. If the participant does not have a disability, the provider is not required to supply the food substitutions.

The parent/guardian may request a nutritionally equivalent substitute for fluid milk without medical professional direction. This site chooses to offer this nutritionally–equivalent product: _____. Check here if you would like to request the soy milk listed in place of fluid milk and list the reason for the request. ❑ _____

USDA allows a parent/guardian to supply substitute foods. Check here if you wish to provide the substitute foods: ❑

Parent/Guardian signature: _____ Date:_____
(To document choices and for permission to release information)

USDA is an equal opportunity employer and provider.

Developed by the Iowa Department of Education, Bureau of Nutrition and Health Services 8/2015

Check the box in front of food groups that should NOT be served and list the foods to be served instead.

Lactose/milk – *Do not serve the items checked below:* ☐ Fluid milk as a beverage or on cereal? ¼ cup of fluid milk to be used on cereal? __yes __no ☐ Milk based desserts such as ice cream and pudding ☐ Hot entrees with cheese as a prime ingredient such as grilled cheese, cheese pizza, or macaroni & cheese ☐ Cheese baked in products such as a casserole or on meat pizza ☐ Cold cheese such as string cheese or sliced cheese on a sandwich ☐ Milk in food products such as breads, mashed potatoes, cookies or graham crackers	**SERVE THESE ITEMS INSTEAD:**
Soy - *Do not serve the items checked below:* ☐ Protein products extended with soy ☐ Processed items cooked in soy oil ☐ Food products with soy as one of the first three ingredients ☐ Food products with soy listed as the fourth ingredient or further down the list	**SERVE THESE ITEMS INSTEAD:**
Egg - *Do not serve the items checked below:* ☐ Cooked eggs such as scrambled eggs or hard cooked eggs served hot or cold ☐ Eggs used in breading or coating of products ☐ Baked products with eggs such as breads or desserts	**SERVE THESE ITEMS INSTEAD:**
Seafood – *Do not serve the items checked below:* ☐ Fish ☐ Shrimp ☐ Crab ☐ Oysters ☐ Other:_____	**SERVE THESE ITEMS INSTEAD:**
Peanuts – *Do not serve the items checked below:* ☐ Peanuts, individually or as an ingredient ☐ Foods containing peanut oil ☐ Foods items identified as manufactured in a plant that also handles peanuts	**SERVE THESE ITEMS INSTEAD:**
Tree nuts – *Do not serve the items checked below:* ☐ All nuts ☐ Food items identified as manufactured in a plant that also handles nuts ☐ Other: _____	**SERVE THESE ITEMS INSTEAD:**
Wheat – *Do not serve the items checked below:* ☐ Foods containing wheat ☐ Foods containing gluten ☐ Other: _____	**SERVE THESE ITEMS INSTEAD:**

IOWA SCHOOL-AGE CARE - HEALTH STATUS - PARENT STATEMENT

Parents complete this page

Please use a checkmark in the box ☐to all the sentences that apply to your child.

Date of child's last physical exam: _____

Growth
☐ I am concerned about my child's growth.

Appetite
☐ I am concerned about my child's eating habits.

Rest - My child
☐ May need to rest or sleep after school.

Illness/Surgery/Injury - My child
☐ Had a serious illness, surgery, or injury.
Please describe:

Physical Activity - My child
☐ Must restrict physical activity or needs special equipment to be active. Please describe:

Play with friends - My child
☐ Plays well in groups with other children.
☐ Will play only with one or two other children.
☐ Prefers to play alone.
☐ Fights with other children.
☐ I am concerned about my child's play activity with other children.

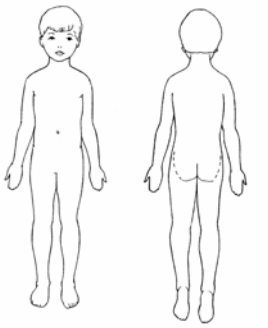
School and Learning - My child
☐ Is doing well at school.
☐ Is having difficulty in some classes.
☐ Does not want to go to school.
☐ Frequently misses or is late for school.
☐ I am concerned about how my child is doing in school. Please describe:

☐ **Allergy** - My child has allergies (list any allergies to food, medicine, fabric, inhalants, insects, animals, etc.):

Child has Epipen, inhaler, or other emergency medication.
☐ Yes ☐ No

Body Health - My child has problems with

☐ Skin, hair, fingernails or toenails. Describe skin marks, birthmarks, or scars. Show us where these skin marks are located using the drawing below.



☐ Eyes \ vision, glasses or contact lenses
☐ Ears \ hearing, hearing assistive aides or device, earache, tubes in ears
☐ Nose problems, nosebleeds
☐ Mouth, teeth, gums, tongue, sores in mouth or on lips, breaths through mouth
☐ Frequent sore throats or tonsillitis
☐ Breathing, asthma, cough
☐ Heart problems or heart murmur
☐ Stomach aches or upset stomach
☐ Trouble using toilet or wetting accidents
☐ Hard stools, constipation, diarrhea, watery stools
☐ Bones, muscles, movement, pain moving
☐ Mobility, uses assistive equipment _____
☐ Nervous system, headaches, seizures, or nervous habits (like twitches or tics)
☐ Female monthly periods
☐ Other special needs. Please describe:

☐ **Medication**[1] - My child takes medication.
Medication Name Time Given Reason for giving medication

Note to parents: **Certificate of Immunization**
School-owned and operated child care programs located on school property may file/store your child's Certificate of Immunization in the school office or in the school nurse's office. All other school-age child care programs must keep the Certificate of Immunization on-site at the child care facility not off-site.

Parent Signature:
(required)

[1] Please review the child care program policies about the use of medication while your child is at the program.

IOWA SCHOOL-AGE CARE - HEALTH STATUS - PARENT STATEMENT

Doctors complete the **Physical Exam Form***

Date of Physical Exam:

Height:_____ Weight: _____

Body Mass Index: _____,

☐ There are weight concerns and

☐ Referral made to _____

Blood Pressure:

Laboratory Screening:

Blood Lead Level: _____ ☐ venous ☐ capillary (for child under age 6 yr)

Hgb. / Hct:

Urinalysis:

TB testing (high risk child only)

Sensory Screening

Vision: Right eye _____ Left eye _____

Hearing: Right ear _____ Left ear _____

Tympanometry: Right ear _____ Left ear _____

Exam Results *(N = normal limits) otherwise describe*

Skin:

HEENT:

Teeth/Oral health:

Date of Exam by Dentist: _____ or ☐ None to date.
Dental Referral Made Today ☐ Yes ☐ No

Heart:

Lungs:

Stomach/Abdomen:

Genitalia:

Extremities, Joints, Muscles, Spine:

Neurological:

Other Notes:

Child Birthdate: **Age:**

Vaccines given Today:
Vaccines entered into IRIS database. ☐ Yes ☐ No

DtaP/DTP/Td

HEP B

HIB

Influenza

MMR

Pneumococcal

Polio

Varicella

Other

Referrals made Today:

☐ Referred to ***hawk-i*** today 1-800-257-8563

Health provider authorizes the child to receive the following medications while at child care or school
(Including *over-the-counter* and *prescribed*)

Medication Name Dosage

Pain reliever:

Sunscreen:

Cough medication:

Health Provider Statement:

☐The child may **fully participate** with ***NO*** health-related restrictions.

☐The child has the following **health-related restrictions** to participation: (please specify)

Signature _____
Provider Type (circle) MD DO PA ARNP

Address: May use stamp

Telephone:

* Iowa Child Care regulations require an annual parent statement about the child's health. Parents obtaining a physical exam are asked to have their family doctor or clinic use this form.

IOWA SCHOOL-AGE CARE - HEALTH STATUS - PARENT STATEMENT

Parents: A physical exam for school-age children enrolled in child care is not required every year. However, school-age children need to continue to receive health care to prevent illness and to identify potential health problems. The following guide will help you and your child prepare for a thorough physical exam with your family doctor. If you do not have a family doctor, please call the Healthy Families Line (**1-800-369-2229**) to locate a health care provider near you.

Iowa Recommendations for Preventive Health Care – School-Age Youth

Health Provider Guide	5 yr.	6yr.	8 yr.	10 yr.	12 yr.	14 yr.	16 yr.
History: Initial and Interval	●	●	●	●	●	●	●
Measurement: Height/ Weight and Body Mass Index	●	●	●	●	●	●	●
Blood Pressure	●	●	●	●	●	●	●
Nutrition: Assessment/ education for food intake and physical activity	●	●	●	●	●	●	●
Development/School Achievement: Screening or questionnaire	●	●	●	●	●	●	●
Mental Health / Mood: Screening questionnaire	●	●	●	●	●	●	●
Sensory Screen: Vision (This screening may be completed at school or in child care)	I	I	I	●	I	I	●
Hearing	I	●	●	●	I	●	●
Oral Health assessment: dental history, recent concerns, pain or injury, visual inspection or oral cavity	●	●	●	●	●	●	●
Dental exam	Dentist exam or refer to dentist every 6 months						
PHYSICAL EXAM	●	●	●	●	●	●	●
Lab tests: Hematocrit or Hemoglobin and (hemoglobinopathy for adolescents at risk)					◄	●	►
Urinalysis	●				◄	●	►
Lead Test[2]	●						
Cholesterol Screen	◆						
STD Screen and Genital or Pelvic Exam[3]						◆	►
TB test[4]	◆	►	►	►	►	►	►
Immunizations: *per Iowa schedule*[5]	●	●	●	●	●	●	●
Family Guidance: Injury Prevention	●	●	●	●	●	●	●
Seat Belt Use	●	●	●	●	●	●	●
Bike Helmet Use	●	●	●	●	●	●	●
Violence Prevention[6]	●	●	●	●	●	●	●
Nutrition & Physical Activity Counseling	●	●	●	●	●	●	●
STD and Pregnancy Prevention for males and females[7]	●	●	●	●	●	●	●

Key: ● To be performed **I** = Interview parent or child ◆ =Done for at risk children
►Arrow indicates range which item may be completed

[2] Lead testing Iowa Lead Testing program 1-800-242-2026.
[3] Sexually active youth should be screened.
[4] TB testing for at-risk children Iowa TB program 1-800-383-3826.
[5] Immunization per schedule Iowa Immunization 1-800-831-6293.
[6] All families to receive domestic and youth violence prevention. CALL TEENLINE 1-800-443-8336 (operates 24/7).
[7] All youth to have access to STD and pregnancy prevention services. CALL TEENLINE 1-800-443-8336.