First United Methodist Church • 607 Lynn Street • Tipton, IA 52772
563.886.2331 • lfp@tiptonumc.org

Dear Parents,

Thank you for choosing Little Friends Preschool as a stepping-stone on your child's educational path! While providing a setting for learning, creativity and fun, we want your child to grow and know how special they are because they are God's little friend!

In Order for your child to come to preschool, you must fill out the attached forms completely and return to the church by August 1 accompanied by a nonrefundable $40 registration fee. Along with the registration forms, your child must be potty-trained and be the age of 3 by the time school starts. Included in these forms are:

- Parent/child address, phone number, email address, and parent work place
- Doctor/Dentist information
- Copy of physical within the last 12 months (Please have the doctor fill out our physical form)
- We will also need a current copy of your child's immunization records on the Iowa Dept. of Public Health form.

You may mail the forms back, or deliver them to the church. When you enter the breezeway, turn left, and right inside the double doors is the mail slot labeled for Little Friends Preschool. Starting in September, this is also the area to drop off tuition payments at the start of each month. Tuition rates are:

- 3-year-old – Tuesday/Thursday 9–11:30 am: $120 per month
- 3-year-old – Monday/Wednesday/Friday 9–11:30 am: $150 per month

Important dates to mark on your calendar:

- August 1: Registration forms complete and turned in to the church office
- Last Sunday in August: Meet-and-Greet at 6:00 pm. Come to the church for a tour, refreshments, and information for the coming year!
- First Tuesday after Labor Day: Classes start for Tuesday/Thursday class
- First Wednesday after Labor Day: Classes start for Monday/Wednesday/Friday class

Little Friends Preschool is open to anyone and any denomination, not just members of the Tipton First United Methodist Church. Scholarships are also available based on income. Thank you again for choosing Little Friends Preschool. If you have any questions, please contact the church office.

Looking forward to meeting you!

Little Friends Preschool & Board

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Financial Contract: 2024–2025

Child's Name: _____ Date of Birth: _____

Starting Date: _____ Class: _____

1. I agree to pay tuition in the amount of $ _____ monthly, due on the first school day of the new month. If monthly creates a hardship, I/we have agreed to pay on the following $ _____ weekly/biweekly/ _____.
2. The registration fee of $40 is non-refundable.
3. A returned check from a bank is assessed a fee of $25 for processing.
4. There are no refunds made for days missed due to illness, snow, vacation, or holidays.
5. We ask that you provide written, two week notice prior to your child's last day of attendance if it is prior to the end of the school year. This is a courtesy to any family who may be on the waiting list, so they have a chance to prepare for their 'first day of school.'
6. Tuition Rates: (circle or mark the class your child will attend.)
   3-year-old – Tuesday/Thursday 9–11:30 am: $120 per month
   3-year-old – Monday/Wednesday/Friday 9–11:30 am: $150 per month
7. LFP intends to hold every class noted. However, if minimum class sizes are not met a class cannot be offered. In such a case any payments received by LFP will be returned to the family.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

LFP Staff Signature: _____ Date: _____

Printed Name: _____

Please fill out this page and return. KEEP the first page of this letter for your records.

Parent(s) Name: _____

Child's Name: _____

Class Preference (parents of 3-year-olds, circle which best fits your schedule)

I prefer Tuesday/Thursday I prefer Monday/Wednesday/Friday

We will give preference to those who were on our list first and then work our way down according to the information we receive from this. If part of the scheduling involves children from the same child care setting or some carpool, make a note here.

_____

****

T-Shirts

We will be ordering Little Friends Preschool t-shirts for the children.
Write your child's name & circle a size here:
Student's Name: _____ T-shirt Size: 3T 4T 5T

****

Permission to Photograph

I, _____ give my permission for Little Friends Preschool to use photos/video of my child(ren) _____ for the purposes or settings listed and only those which I have marked. I reserve the right as a parent to withdraw my permission in writing at any time.

____ Class projects that may be posted in the hallway of the school/church.

____ Records or scrapbooks of LFP happenings.

____ To be shown on the LFP limited-access Facebook group.
(Only LFP families and LFP Staff & Board are given access.)

____ For use to advertise or publicize the impact of LFP. (The best publicity is pictures of happy, smiling, working and playing children!) [Said publicity may include projection in a service of worship or other in-house settings; with Board of Directors of LFP or the Council of the church; or even Cedar-Jones Early Childhood Iowa where funding requires making a strong statement of the impact LFP is making on the lives of children and families.]

OR:

I, _____ do not give my permission for photos of my child to be used for any purpose.

Signature: _____ Date: _____

Signature: _____ Date: _____

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Pick-Up Authorization Form

Child's Full Name: _____

Child's Age: _____

I hereby give permission for my child to leave the center with the following persons identified below. It is my responsibility to notify the center in writing of any changes to this authorization.

Name: _____ Phone Number: _____

Address: _____ Relationship to Child: _____

Name: _____ Phone Number: _____

Address: _____ Relationship to Child: _____

Name: _____ Phone Number: _____

Address: _____ Relationship to Child: _____

Is there a court order prohibiting contact with my child by any person?

____ Yes If 'Yes' please provide photocopy of order.

____ No

Name of prohibited person _____ Relationship _____

Is there any child custody order of which we need to be aware? _____

If so, please advise: _____

Name(s) of person(s) who MAY NOT pick up my child:

_____

_____

_____ _____

Signature of Parent or Guardian Date/Year

Child Enrollment Information

Child Information			
Child's Name:		**Date of Birth:**	
Address:	**City:**	**State:**	**ZIP:**
Allergies, special instructions, comforting items:			

Parent/Guardian Information (1)			
Name:		**Relationship to child:**	
Address: (if different than child)	**City:**	**State:**	**ZIP:**
Home #:	**Cell #:**	**Work #:**	
Email (personal):		**Email (work):**	
Place of work:		**Address:**	

Parent/Guardian Information (2)			
Name:		**Relationship to child:**	
Address: (if different than child)	**City:**	**State:**	**ZIP:**
Home #:	**Cell #:**	**Work #:**	
Email (personal):		**Email (work):**	
Place of work:		**Address:**	

Emergency Contact (1)			
Name:		**Relationship to child:**	
Address:	**City:**	**State:**	
Home #:	**Cell #:**	**Work #:**	
Email (personal):		**Email (work):**	

Emergency Contact (2)			
Name:		**Relationship to child:**	
Address:	**City:**	**State:**	
Home #:	**Cell #:**	**Work #:**	
Email (personal):		**Email (work):**	

Emergency Contact (3) – Out-of-Area/Out-of-State			
Name:		**Relationship to child:**	
Address:	**City:**	**State:**	
Home #:	**Cell #:**	**Work #:**	
Email (personal):		**Email (work):**	

Medical Information		
Child's Doctor's Name:		**Phone #:**
Address:	**City:**	**State:**
Preferred Hospital to Contact:		**Phone #:**
Address:	**City:**	**State:**

Child's Dentist's Name:		**Phone #:**
Address:	**City:**	**State:**

Does your child have any special needs that I need to be aware of? _____

_____

_____

Persons allowed to pick up my child if I am unable to: **(Also list emergency contacts below if you want to allow them to pick up your child)**		
Name:	**Phone #:**	**Relationship to child:**
Name:	**Phone #:**	**Relationship to child:**
Name:	**Phone #:**	**Relationship to child:**
Name:	**Phone #:**	**Relationship to child:**
Name:	**Phone #:**	**Relationship to child:**
Name:	**Phone #:**	**Relationship to child:**

Any one NOT allowed to pick up my child (with copy of court order, if applicable):

Parent's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

Consent & Release

Name of Facility: _____ Address of Facility: _____

Name of Child: _____

The following persons are allowed to pick up my child from child care in the event that I am unable to:

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Anyone **NOT** permitted to pick up my child (with copy of court order, if applicable):

_____	_____	_____
_____	_____	_____

Consent is given for the items initialed below:

_____ Walking Trips

To the following: _____

_____ Motor Vehicle Trips

Type of vehicle: _____ To the following: _____

Child restraint system to be used: _____

Special needs of child during transport: _____

_____ Daily Transportation

Type of vehicle: _____ To/from the following: _____

Child restraint system to be used: _____

Special needs of child during transport: _____

_____ Swimming and/or Wading

Location: _____

_____ Other Activities (e.g. homework supervision, trips to neighborhood playgrounds, special trips)

Description: _____

_____ Photo Release

My child may be photographed while in child care. Photos may be used in newspapers or other media for the purpose of publicity or shared with other families whose children attend the child care program.

_____ Decline Photo Release

Do not photograph my child while in the child care program.

_____ _____

Signature of Parent 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/PPSV			
Meningococcal MCV/MPSV/ Mening B			
Hepatitis A			
Rotavirus			
Human Papilloma Virus HPV			
Other			

January 2013

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 if the applicant received 1 dose before 15 months of age; or 1 dose if 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 2 doses if only 1 dose received before 15 months of age; or 1 dose if received when the applicant is 15 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 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, unless the applicant has a reliable history of natural disease.
	24 months of age 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 2 doses if only 1 dose received before 15 months of age; or 1 dose if received when the applicant is 15 months of age or older. **Hib vaccine is not required 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 24 months of age; or 2 doses if the applicant received 1 dose before 24 months of age; or 1 dose if the applicant did not receive any doses before 24 months of age. **Pneumococcal vaccine is not required 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, 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[4, 5]	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 [2]; 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 on or before September 15, 2003[2]; 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 after September 15, 2003 [2, 3];and 1 time dose of tetanus/diphtheria/acellular pertussis-containing vaccine (Tdap) for the applicant in grades 7 and above, if born after September 15, 2000; regardless of the interval since the last tetanus/diphtheria-containing vaccine.
		Polio	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[7] ; 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.[6] **Polio vaccine is not required for persons 18 years of age or older.**
		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
		Varicella	1 dose received on or after 12 months of age if the applicant was born on or after September 15, 1997, but born on or 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 after September 15, 2003, unless the applicant has a reliable history of natural disease.[8]
		Meningococcal (A, C, W, Y)	1 dose of meningococcal vaccine received on or after 10 years of age for the applicant in grades 7 and above, if born after September 15, 2004; and 2 doses of meningococcal vaccines for the applicant in grade 12, if born after September 15, 1999; or 1 dose if received when the applicant is 16 years of age or older.

1 Mumps vaccine may be included in measles/rubella-containing vaccine.

2 DTaP is not indicated for persons 7 years of age or older, therefore, a tetanus and diphtheria-containing vaccine should be used.

3 The 5th dose of DTaP is not necessary if the 4th dose was 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 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.

5 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.

6 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.

7 If both OPV and IPV were administered as part of the series, a total of 4 doses are required.

8 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.

Infant, Toddler, Preschool Age – Child Health Form

HEALTH PROFESSIONAL COMPLETE THIS PAGE

Child's Name: _____

Birthdate: _____ **Age today:** _____

Date of Exam: _____

Height/Length: _____ Weight:_____

BMI– starting at age 24 mo. _____

Head Circumference- age 2 yr. and under: _____

Blood Pressure-start @ age 3 yr:_____

Hgb or Hct- @ 12 mo: _____

Lead Risk Assessment:_____

Blood Lead Level: date_____ results _____

Sensory Screening:

Vison Assessment: _____

Vision Acuity: Right eye _____ Left eye _____

Hearing Assessment: Right ear _____ Left ear _____

Tympanometry (may attach results)

Developmental Screening/Surveillance:

(n = normal limits) otherwise describe

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

Date of Dental exam _____

Oral Health/Dental Referral Made Today: ☐Yes ☐ No

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Health Care Provider comments:

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Immunization: Please attach:

☐ Iowa Department of Public Health Certificate of Immunization

☐ Iowa Department of Public Health Certificate of Immunization Exemption Medical

☐ Iowa Department of Public Health Certificate of Immunization Exemption Religious.

☐ TB testing completed (only for high-risk child)

Medication: Health professional authorizes the child may receive the following medications while at the child care facility: (include *over-the-counter* and *prescribed*)

Medication Name Dosage

☐ Diaper crème:

☐ Fever or Pain reliever:

☐ Sunscreen:

☐ Other

Other Medication should be listed with written instructions for use in child care. Medication forms available at www.idph.iowa.gov/hcci/products

Referrals made:

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

☐ Other: _____

Health Provider Assessment Statement:

☐ The child may participate in developmentally appropriate early care/learning with ***NO*** health-related restrictions.

☐ The child may participate in developmentally appropriate early care/learning ***with restrictions*** (see comments).

☐ The child has a special needs care plan

Type of plan _____

(please attach)

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 and annually.
The American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures 2015)
https://www.aap.org/en-us/Documents/periodicity_schedule.pdf