Discovery Time Preschool
A time to learn, share & discover.

Iowa QRS

Preschool Registration Form 2022-2023

$50.00 non-refundable registration is due at the time of enrollment to reserve a spot.
Registration documents will be available online- to be completed and turned in at our Open House in August.
For any questions contact us at discoverytimeprek@gmail.com or www.discoverytimeprek.com

Child's Name:_____ Child's Date of Birth:_____
Parent's Name:_____ Gender M/F
Address:_____
Phone#s_____
Email: (required) _____

You are registering your child for Discovery Time Preschool. At this time, we offer one multi-age class for students 3-5yrs old on Mondays, Wednesdays, and Fridays 9am-11:30am

☐ 3 days/week (Mon/Wed/Fri)-$115/month
Registration Fee-- $50 (Due at registration)

Wednesday Lunch & Learn 11:30am-1pm
Your child will bring a sack lunch from home to eat and we will provide enriched learning opportunities including math, science, literacy, and art projects.

☐ Wednesdays-$25/month

Children must be toliet trained before beginning school.
Tuition assistance is available.

Financial Aid
SEP has grant money available to provide preschool tuition for local families. Please apply for the RAMS All Star Program with Central Place at 515-957-5664.

Name of person(s) (other than a parent. ex. child care provider) that will transport your child. (if applicable)
_____

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Identification Information

Child's Name _____ Birthdate _____ M / F

Address_____

If child prefers to use a nickname, please list the name he/she will be using

_____

Parent Name _____

Address _____ Phone Number _____

Place of Employment _____Phone Number _____

Email address:_____

Parent Name _____

Address _____Phone Number _____

Place of Employment _____Phone Number _____

Email address:_____

Guardian or Custodian other than parent (if applicable)

Name _____

Address _____ Phone Number _____

Child Care (if applicable)

Name _____

Address _____ Phone Number _____

Family History

Marital Status of Parents: Married _____ Divorced _____ Separated _____

Widowed _____ Single _____

Please indicate if there are special circumstances that restrict access to this student and provide and supporting documentation (i.e. copy of a court order) to be kept in your child's file.

Other Children in the Home (name and birthdate):

_____ _____

_____ _____

Church Your Family Holds Membership In: _____

Physical Regime

Does your child have any unusual eating problems or food allergies? (Explain)

_____

Do you consider your child to be right-handed?_____ left-handed?_____ not sure?_____

What is your child's usual bed time _____ usual waking time _____

What is your child's attitude toward going to bed and taking a nap?_____

If your child has had the chicken pox disease, how old was your child?_____

PLEASE COMPLETE FRONT AND BACK OF FORM

Play and Social Skills

How does your child get along with other children?

_____

Are your child's playmates girls _____ boys _____ younger _____ older _____

What is the usual size of neighborhood play group? _____

Previous group experience: preschool _____ play group _____

Sunday School _____

Personality and Emotional Development

Do you regard your child as affectionate? _____ To whom? _____

Does your child accept new people easily? _____

What are your child's fears? _____

What is your child's usual temperament? _____

What nervous habits does your child have? _____

When does your child show them? _____

When you find it necessary to discipline your child, what form of discipline works best for your child?

_____

_____

Give any further information which you believe will be helpful to us in understanding your child. (In case of handicap - describe) _____

_____

_____

Please let us know if you have a family emergency such as family members in the hospital or any other changes in the home. This will enable us to understand if your child's behavior changes.

PLEASE COMPLETE FRONT AND BACK OF FORM

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:

Please complete front and back of this form

PARENTS **COMPLETE THIS PAGE** **Child's Name:** _____

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.

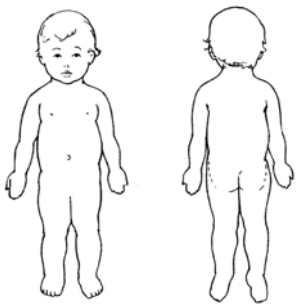
Development and Learning
☐ I am concerned about my child's behavior, development, or learning.
Please describe:

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

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.

[1] Iowa Child Care Regulations require an admission physical exam report within the previous year. Annually thereafter, a statement of health condition signed by an approved health care provider. The American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (RE9939, March 2000) www.aap.org

[2] Developmental screening procedures were expanded to include autism, developmental surveillance, and psychosocial/behavioral screening July 2009 by the Iowa EPSDT Medicaid program. Toll-free 800-383-3826.

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Immunization: May attach a copy of Iowa Department of Public Health Immunization Certificate

DtaP/DTP/Td	MMR
Hepatitis B	Pneumococcal
HIB	Varicella
Polio	Other
Influenza	

TB testing (only for high-risk child)

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

Medication Name Dosage

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

Other Medication should be listed with written instructions for use in child care.

Referrals made:

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

Health Provider Assessment Statement:

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

☐ The child may participate in developmentally appropriate child care/preschool ***with the following restrictions***:

May use stamp

Signature _____
Circle the Provider Credential Type: MD DO PA ARNP
Address: Telephone:

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

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[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.

Iowa Department of Public Health
CERTIFICATE OF DENTAL SCREENING

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

Student Information (please print)

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

Screening Information (health care provider must complete this section)

Date of Dental Screening: _____

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

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

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

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

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

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

Provider Name: (please print) _____ Phone: _____

Provider Business Address: _____

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

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

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

Iowa Department of Public Health • Oral Health Center
515-242-6383 • 866-528-4020 • www.idph.state.ia.us/ohds/OralHealth.aspx
A designee of the local board of health or Iowa Department of Public Health may review this certificate for survey purposes.

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Medical/Dental Insurance

_____ _____

(Student first, middle, last name) **(Date of birth)**

Do you have private health insurance? _____ Yes _____No
If yes, name the provider_____
_____I do not have private insurance, but I have Hawk-i or Government Assisted Insurance.
_____No, I do not currently have a health insurance for my child.

Discovery Time Preschool is required to have a copy of your child's medical insurance card on file. Please attach a copy (front and back) of your student's medical insurance card.

Do you have dental insurance? _____ Yes _____No
_____I do not have private insurance, but I have Hawk-i or Government Assisted Insurance.
_____No, I do not currently have a health insurance for my child.

Discovery Time Preschool is required to have a copy of your child's dental insurance card on file. Please attach a copy (front and back) of your student's dental insurance card.

If you do not have insurance for your child, information can be provided to you that will explain options for free health insurance for children.

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.

Rev: 1-10

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Pick-up and Emergency Care Permission Form

Students Name:_____ Date of Birth:_____
(List student's first, middle, last name)

On this form you will tell us who is allowed to pick up your student after class or after a Discovery Time Preschool off-site activity. We will not allow your child to leave with someone who is NOT on this list.
If there is a separation or divorce custody problem of which we should be aware, please explain.
_____

Individuals that we are not familiar with will be asked to present identification. Parents must include their name to this list.
I hereby GRANT permission for my child to leave Discovery Time Preschool with any of the following people listed below. I understand that if there are any changes that need to be made to this list, it is my responsibility as parent/guardian to provide *written* notification to the preschool staff.
Name of person who may NOT pick up the child:
_____

I understand that in the event of an emergency, Discovery Time Preschool staff will make every effort to contact a parent/guardian first. **I hereby GRANT permission to Discovery Time Preschool to obtain EMERGENCEY MEDICAL or DENTAL CARE even if they are unable to immediately make contact with me (the parent/guardian).** I understand that if I cannot be reached, Discovery Time Preschool will contact the individuals indicated below. In addition, all individuals on this list may be contacted if my child isn't picked up in a timely manner. **You must have at least one person outside of your home on this list.**

Signature: _____ Date:_____

Names of those who are allowed to pick up my child **1) Parents, please include your names** **2) First person listed will be your FIRST emergency contact person** **3) Include at least one person outside of home**	**Relationship i.e. Mother, Father, Grandparent, Daycare**	**Contact in an emergency? (Yes/No)**	**Contact Phone Numbers**
FIRST EMERGENCY CONTACT PERSON			

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Release & Authorization Permission Form

Student's name: _____

Picture Release:

☐ I give permission for my child to be photographed or videotaped by Discovery Time Preschool to be used but not limited to:

- Labeling student items
- Class photos
- Student or school projects
- Newspapers
- Church/Preschool website or newsletter for publicity/advertising/familes
- Communication items
- School program media presentations or other DTP offerings
- Discovery Time Preschool official Facebook page and other official social media used

Parent/Guardian Signature: _____ Date:_____

Travel and Activity Authorization:

☐ I give my permission for my child to leave the Discovery Time Preschool with teachers and staff for trips in a vehicle or walking field trips. Trips include but are not limited to parks, libraries, etc. within proximity of the preschool. I will receive information about any trips in which my child is invited to participate.

Parent/Guardian Signature: _____ Date:_____

Southeast Polk Release of Information Authorization: (this only applies to 4/5 yr. olds)

☐ I give my permission to Discovery Time Preschool to give our contact information to Southeast Polk School District so that the school district can send us Kindergarten information.

Parent/Guardian Signature: _____ Date:_____

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Dear Families,

An important part of our program's success is the willingness of parents to be involved and participate in activities. To assist us in our planning please take a moment to fill out the volunteer form. Many of the activities we'd like to do will depend on help from parents. Please let us know if you can help us in any of the ways listed below (or in other ways we haven't thought of.) Educational research says children benefit greatly when parents are involved in their child's education. We appreciate your assistance and willingness to volunteer.

Thanks!
Discovery Time Preschool

Parents' Name: _____ Phone: _____
Child's Name: _____

_____I would like to participate in the parent group.
_____I would like to be an occasional volunteer aide in the classroom. (Background check will be performed and may be at the expense of the volunteer.)
Day(s) Available: _____ Time(s) Available: _____
_____I am available to help with classroom parties. (Planning and/or treats)
_____I would be interested in helping with a fund-raiser for the preschool.
_____I can donate supplies when requested.
_____I can bring cookies for Christmas/Graduation Programs.
_____I can share a special talent or interesting hobby.
_____I can serve as a parent rep on the Preschool Board.
_____Other, please explain. _____