

IV. Physical Habits:

Does your child have any food allergies or dislikes? (Explain) _____

Hand preference: Left _____ Right _____ Unknown _____ Both _____

V. Social/Emotional Development:

Describe your child's previous group/play experience(s) with other children: _____

Does your child have a special interest? _____

What are your child's fears? _____

When does he/she show them? _____

When you find it necessary to discipline your child, what type of discipline do you find to be most effective? _____

How does your child respond to discipline? _____

VI. Give any further information that you believe will be helpful to us in understanding your child (past health history, home-family situations, child's behavior, speech or hearing problems, allergies, etc.)

(If you have any additional information, please use an additional sheet and attach it to this page)

VII. Parent involvement:

If possible, would you like to be periodically involved in the program as a volunteer? _____

Do you have any special talents, services, or a career you would be willing to share with us? If so, explain.

Would you be interested in becoming a parent representative on the Preschool Board of Directors? Yes _____ No _____

What would you most like your child to gain from preschool this year? _____

What influenced your decision to send your child to Wee Care? _____

Wee Care Preschool (2023-2024)

Pick-Up Authorization Form

Child's Full Name: _____

Child's Birthdate: _____

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	Address	Phone No.	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is there a court order prohibiting contact by any person?

____ Yes ____ No If 'Yes,' please provide a photocopy of the court order.

Name of prohibited person _____ Relationship _____

Is there any child custody order of which we need to be aware? _____ If so, please advise:

Name of persons who may not pick up my child:

This consent **will be in effect for one year** beginning _____

Signature of Parent or Guardian

Date

Immanuel Lutheran Preschool (2023-2024)
Permission Form

(Circle one)

I **do/do not** give permission for my child _____ to leave the preschool facility for various trips to special places. I understand I will be notified before each activity and that all drivers will be licensed and insured.

Restrictions on such field trips:

1. Each child will be secured in a car seat (provided by parents) for any car trips.
2. No snack will be given in the vehicle.
3. (Additional restrictions, if any, set by parents)

(Circle one)

I **do/do not** give my permission for Immanuel Lutheran Preschool to use my child's picture of school activities in the newspaper, Immanuel Lutheran Church directory, and/or other publications (including Facebook) promoting the preschool.

I **do/do not** give my permission for my child to wear sunscreen when going outside while attending Immanuel Lutheran Preschool (I understand that I must provide the sunscreen for my child's use).

This consent **will be in effect for one year** beginning _____

Signature of Parent or Guardian

Date

Immanuel Lutheran Preschool Parental (2023-2024)

Emergency Medical Consent Form

This form must be presented upon admission for treatment. If numbers change, please notify the school.

Child's Full Name _____ Birthdate _____
(last) (first) (middle)

This form allows parents and guardians to authorize the provision of emergency treatment for above-named child who becomes ill or injured while under program authority when parents or guardians cannot be reached.

In the event reasonable attempts to contact me at _____ (phone number) or _____ (phone number) have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by Doctor _____ (physician) at _____ (phone number) or Doctor _____ (dentist) at _____ (phone number) or in the event the designated practitioners are not available, then by another licensed physician or dentist; and the transfer of the child to _____ (preferred hospital).

1. Parents/Guardians with Whom the Child Resides:

Name _____ Relationship _____

Address _____ Phone _____

Work Phone _____ Place of Work _____

Name _____ Relationship _____

Address _____ Phone _____

Work Phone _____ Place of Work _____

2. Persons to Contact in Case of Emergency if Parents Are Unavailable, and are Authorized to Pick Up Child:

Name _____ Relationship _____

Address _____ Phone _____

Work Phone _____ Place of Work _____

Name _____ Relationship _____

Address _____ Phone _____

Work Phone _____ Place of Work _____

3. Information:

Physician name _____ Dentist name _____ Choice Hospital _____

Street address _____ Street address _____ Street address _____

City, State _____ City, State _____ City, State _____

Phone Number _____ Phone Number _____ Phone Number _____

Date of Last Tetanus Known Allergies Present Medications

Insurance Company Policy Holder's I.D.

This consent **will be in effect for one year** beginning _____

Signature of Parent or Guardian

Date

Immanuel Lutheran Preschool (2023-2024)

Physical Form

Fax Number: 319-334-4596

Name _____ Gender _____
(last) (first) (middle)

Parent(s)/Guardian(s) _____
Address _____

Parent(s)/Guardian(s) _____
Address _____

Parent(s)/Guardian(s) _____
Address _____

Date of Birth _____ Birth Weight _____

Any birth complications _____

(child's physician fills out below)

Height _____ Weight _____

Illnesses:	Age		Age
Asthma or wheezing _____		Whooping cough _____	
Heart disorder _____		Mumps _____	
Seizures or spells _____		Chicken pox _____	
Eczema or hives _____		Pneumonia _____	
Scarlet fever (Scarlatina) _____		Colds: susceptible - Yes _____	
Measles _____		No _____	
Rubella (German measles) _____		Recurrent ear infections - Yes _____	
		No _____	
Other _____			

Any special health precaution we should be aware of? _____

Allergies (medication, food, hay fever, etc.) _____

Injuries, accidents _____

Identifying marks (birth makes, scars, etc.) _____

On regular medication? _____

Summary of findings and recommendations:

I have examined _____.
In my opinion he/she is _____ or is not _____ physically and emotionally able to participate in a preschool program.
Immunizations: Complete _____ or not complete _____ for age.
Date of next immunizations _____. Please provide a signed copy of current immunizations for this child.

Signature of Physician Date