South Central Calhoun Schools
3-year-old Preschool
2021-2022

Program Facts:

Students must be three-years-old on or before September 15, 2021.

Students must be potty-trained.

Classes meet at both the SCC High School in Lake City and the SCC Elementary School in Rockwell City.

Students attend for 4 days a week (M, T, Th, F).

Morning classes meet from 8:00-11:00 in both Lake City and Rockwell City. Students who eat meals will arrive earlier and leave later. Afternoon classes meet from 12:15-3:15 in Rockwell City and 12:45-3:45 in Lake City.

Breakfast and lunch are provided only for children who are funded by Head Start. Students who eat breakfast and/or lunch at school must eat school meals. Bringing something from home is not permitted.

Tuition is $150 per month for September-April. Eligible students can be funded by Head Start or receive a scholarship from Linking Families and Communities.

Transportation is provided on a limited basis.

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Registration Checklist for 3-year-olds:

- ☐ Complete the pre-enrollment form and return to any school building by April 30.
- ☐ Turn in a copy of your child's birth certificate. This may be turned in at a later date.
- ☐ Turn in proof of a recent physical if not already on file at school. The physical must have been within the last calendar year. Please ask your physician to use the form provided. This may be turned in at a later date.*
- ☐ Turn in proof of a recent dental screening on the provided form. The screening must have been within the last calendar year, and the form must be turned in prior to the first day of school. This may be turned in at a later date.*
- ☐ Provide a valid certificate of immunization with up-to-date immunizations as required by Iowa schedule. This may be turned in at a later date. *
- ☐ Families of students who are funded by Head Start will have additional paperwork to complete with the Head Start Family Advocate.
- ☐ You will receive a letter in May verifying your child's enrollment and assigned section.
- ☐ Complete school registration in August. Dates, times, and locations will be published.

* No child will be allowed to start preschool in the fall without a physical form, dental form, and immunization record on file at the school. Please make your appointments accordingly.

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Pre-Enrollment Form

child's name: ______________ DOB: ____________________________

parent's name: ______________ phone #: __________________________

Is your child currently enrolled in an Early Childhood program? yes no If yes, where? ___________

Do you have any concerns about your child's development? _____________________________________

Is your child potty trained? yes no

Is your gross annual income below $25,000 (family of 4)? yes no FIP/TAN
*Income information is requested in order for the district to access funding for your child's attendance. Please be aware that this information may be shared with Head Start.

I would like my child to attend at the

- ☐ Lake City location.
- ☐ Rockwell City location.
- ☐ no preference.

I would like my child to attend

- ☐ mornings.
- ☐ afternoons.
- ☐ no preference.

If my child is in a morning class, he/she will need transportation from _______________ to school and/or from school to _______________________.

If my child is in an afternoon class, he/she will need transportation from _______________ to school and/or from school to _______________________.

Other factors I would like to have considered when assigning my child to a class: _______________

____.

South Central Calhoun Schools
Preschool Enrollment Form

Student information

Circle one

1. ______________________ PS 3/PS 4 Birth Date: __________ Gender______Race: __________

2. ______________________ PS 3/PS 4 Birth Date: __________ Gender______Race: __________

Please list siblings oldest to youngest on lines 3-6

3. ______________________ Grade: ________

4. ______________________ Grade: ________

5. ______________________ Grade: ________

6. ______________________ Grade: ________

Home Phone #: ______________________ **Primary Language:** __________

Address: ____ **County:** ________

Email Address: ____

Father's name:________________ Mother's name:________________

Father's Cell #: ________________ Mother's Cell #:________________

Father's Employer: ______________ Mother's Employer: ______________

Father's Work #: ________________ Mother's Work #: ________________

In Case of an Emergency and YOU cannot be reached - CONTACT: Name ________________ Phone #______________

If there is another adult in your household who has your permission to act as a parent's authority for your child, please provide information.

Name: ________________ Cell #: ________________ Work #: ________________

If the family has experienced a separation or divorce, please complete this section:

Provide the parent's name and address if the school is expected to mail school information to the parent.

Name: ________________________

Address: ________________________

City, State, Zip: ________________________

Has there been a court order that limits the contact this parent may have with the child, or that restricts parental rights? Yes __ No __

If yes, please provide a copy of the court document to be placed in student's cum. folder.

Signature of Parent/Guardian: ________________________________ Date: ________________

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 pre-school: (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:

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[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.

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 • http://idph.iowa.gov/ohds/oral-health-center
A designee of the local board of health or Iowa Department of Public Health may review this certificate for survey purposes.