WEST DES MOINES UNITED METHODIST
EARLY LEARNING PRESCHOOL
720 GRAND AVENUE WEST DES MOINES, IA 50265
515 279-8897

Dear Parents of Newly Enrolled Children,

Thank you for registering your child at the West Des Moines United Methodist Early Learning Preschool!

FORMS NEEDED BY JULY 1:
The following forms are enclosed and must be completed and returned by July 1—

- Enrollment Form
- Certificate of Immunization Card
- Physician's Medical Report
- Allergy and Medical Emergency Action Plan—is included if we have been informed of an allergy or medical condition for your child.
- Medication Authorization Plan—is included if we have received an Action Plan that states that medication must be administered as part of the emergency plan.

***If your child has an allergy, medical condition or needs medication and we have not been notified, please contact us as soon as possible so that the Action Plan may be mailed to you for completion.**

OTHER ADMISSION REQUIREMENTS:

1. Children must meet the following age requirements—
   3 Year Old Classes-children must be 3 years old by September 15, 2024 in order to enroll for the 2024-25 school year
   2 Year Old Classes-children must be 2 years old by September 15, 2024 in order to enroll for the 2024-25 school year
   Young 2 Year Old Classes-children must be 18 months old by September 1, 2024 and be able to drink from a cup in order to enroll for the 2024-25 school year
2. **A $100.00 Registration Deposit is required at this time for Preschool classes**—it is non-refundable
3. **September tuition is due by July 1**

PARENT ORIENTATION: A Parent Orientation for **parents only** will be held in August. Information will be mailed in July to confirm your child's class assignment and provide you with the Parent Orientation date.

CHILD ORIENTATION: We feel the first hours and days your child spends in our preschool are very important. We do spend time and place emphasis on the orientation of each child. **The first week of school (3 year old and 2 year old classes) or first two weeks of school (young 2 year old classes) the class sessions will be shortened to facilitate your child's adjustment to preschool.** Information about the specific times for the Child Orientation Week will be sent to you in July.

PRESCHOOL COST:

Registration Deposit		$100.00
3 Year Old Monthly Tuition	Monday/Tuesday/Wednesday 9:00-11:30am & 12:30-3:00pm	180.00
2 Year Old Monthly Tuition	Monday/Tuesday/Wednesday 9:00-11:30am	215.00
2 Year Old Monthly Tuition	Thursday/Friday 9:00-11:30am	160.00
Young 2 Year Old Monthly Tuition	Monday/Wednesday & Tuesday/Thursday 9:00-11:30am	160.00

Please send the Registration Deposit for your child as soon as possible if you have not already done so. This will ensure a spot for your child in preschool.

If you have any questions or would like to arrange a visit, please contact me at 515 279-8897 or aborness@wdmumc.org or Teresa Young at tyoung@wdmumc.org.

Thank you again for your interest in our program and welcome to the West Des Moines United Methodist Early Learning Preschool. We are glad you have chosen our preschool!

Amy Borness

Director Of West Des Moines United Methodist Early Learning Preschool

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YOUNG 2'S ENROLLMENT FORM

Child's Name_____ Child's Date of Birth_____ Gender_____
Primary Home Language_____

My child has an Allergy: □ Yes □ No

If yes, please explain_____
Please list any special medical needs that your child may have _____
_____

*If your child has an allergy or medical condition you will be given an Action Plan to complete.

EMERGENCY INFORMATION

In the event parents are unreachable, please list Alternate Numbers in case of emergency:

Name	Relationship	Phone #	Phone #
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____

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: **This section MUST be completed**

Doctor/Clinic Name_____ Phone_____
Doctor Address_____ City, Zip_____
Dentist Name_____ Phone_____
Dentist Address_____ City, Zip_____

***If your child has not been to the dentist, yours may be listed**

Hospital Preferred: (circle one) Blank Children's Broadlawns Lutheran
Unity Point Methodist (downtown) Unity Point Methodist West (60th St)
Mercy One (downtown) Mercy One West Lakes (60th St)

Insurance Company Policy Name and Number_____

I agree to pay all the costs and fees contingent on emergency care or treatment for my child as secured or authorized under this consent.

PICK UP PERMISSION INFORMATION

My child has permission to participate in all field trips (Preschool Pre-K's) and outdoor activities of the Preschool. If he/she is not to participate in a given activity, please notify the Teacher/Director in writing.

I hereby give permission for my child to leave school with the following persons named below. It is the responsibility of the parent to notify the Preschool, in writing, of any changes.

Name/Relationship		Name/Relationship	
1._____	Mother	3._____	
2. ._____	Father	4._____	

*Please note, a pick up restriction of either parent can only be done with a court order. These documents must be kept in the child's file. If there is a separation, divorce, or other custody issue of which we should be aware, please explain____
_____
_____

Are there any persons who may **NOT** pick up your child? □ Yes □ No
If yes, please list _____

PRIMARY HOUSEHOLD INFORMATION

(Address where child resides)

Address_____ City, Zip_____

Name_____ Name_____

Relation to Child _____ Relation to Child_____

Phone_____ Phone_____

Employer_____ Employer_____

Work Phone_____ Work Phone_____

SECONDARY HOUSEHOLD INFORMATION

(Additional legal guardians who do not live at primary household address)

Address_____ City, Zip_____

Name_____ Name_____

Relation to Child _____ Relation to Child_____

Phone_____ Phone_____

Employer_____ Employer_____

Work Phone_____ Work Phone_____

FAMILY/CHILD HISTORY

Marital Status: Married____ Divorced____ Separated ____ Other____

Please list all brothers and sisters in the household (include last names and schools attending)

Name_____ Date of Birth_____ School_____

Name_____ Date of Birth_____ School_____

Name_____ Date of Birth_____ School_____

Has this child attended preschool or child care before? □ Yes □ No

If yes, please list center and dates attended_____

Has this child received services from Heartland AEA or any other agency? □ Yes □ No

If yes, please describe_____

Is this child on an IEP or have they been? (Individualized Education Plan) □ Yes □ No

If yes, for what reason?_____

Does this child have any health or developmental concerns? □ Yes □ No

If yes, please describe_____

AUTHORIZATION INFORMATION

I hereby give permission to the Preschool to use photographs of my child to be displayed in the classroom and/or hallway of the Preschool. My child's first name will only be displayed inside his/her classroom: □ Yes □ No

*If our Preschool would like to include your child's photograph in our Website, Brochure, and/or local newspaper, you will be contacted for permission.

FAMILY EMAIL ADDRESS

Email address_____ * PLEASE PRINT

____ Yes, I authorize you to include my email address on my child's classlist

____ No, I do not have an email address, or I do not want my email address included on my child's classlist

I have read and completed the above information regarding Emergency Information, Medical Consent, Pick-up Permission, and Authorization Information to the best of my knowledge. I consent that the information completed on the Certificate of Immunization Card, Physician's Medical Report, Enrollment Form, Allergy And Medical Emergency Action Plan (if applicable), and Allergy And Medical Emergency Medication Authorization (if applicable) is accurate to the best of my knowledge. I understand that the above information will be used by staff at the West Des Moines United Methodist Early Learning Preschool in order to facilitate the best possible school learning experience for my child.

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 patient has a history of natural disease write "Immune to Varicella"			
Pneumococcal PCV/PPV			
Meningococcal MCV4/MPSV4			
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; 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[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 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 on or after September 15, 2003[2, 3]; and 1 time dose of tetanus/ diphtheria/acellular pertussis-containing vaccine (Tdap) for applicants in grades 7 and above, if born on or after September 15, 2000; regardless of the interval since the last tetanus/diphtheria containing vaccine.
		Polio[7]	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.[6]
		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.[8]

[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, regardless of the applicant's current age.

[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.

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PHYSICIAN'S MEDICAL REPORT

To be completed by physician

Name_____ DOB _____

Parent or Guardian_____

Address_____

Date Of Exam_____

Physical Examination

√ = Normal or Negative

Appearance_____	Speech_____	Back_____
Posture_____	Ears/Hearing_____	Extremities_____
Nutrition_____	Nose_____	Hemoglobin_____
Developmental Screening_____	Throat_____	Blood Pressure_____
Autism Screening _____	Oral/Teeth_____	Urine Analysis_____
Psychosocial/Behavioral Screening_____	Thyroid_____	Lead Screening_____(date)
Neurological _____	Lymph Nodes_____	Height_____
Skin_____	Genitalia_____	Weight_____
Hair/Scalp_____	Hernia_____	Heart_____
Eyes/Vision_____	Abdomen_____	Lungs_____

Developmental Referral Made Today: Yes No

Oral/Health Dental Referral Made Today: Yes No

Eyes/Vision Referral Made Today: Yes No

Allergies_____

Medications_____

Chronic Disease_____

Remedial Defects_____

Program Participation: Full _____ Limited _____
List Limitations_____

Physician's additional comments and recommendations_____

_____

Name of Clinic/Office_____Phone_____
Address_____Zip_____

Physician's Signature_____Date_____

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ALLERGY AND MEDICAL EMERGENCY ACTION PLAN

STEP 1: CHILD INFORMATION

Child's Name_____Date of Birth_____

Phone_____Child'sAddress_____

City_____ Zip_____

Child's Health Condition_____

What are signs/symptoms of this condition?_____

_____

_____

What accommodations should the school make for your child?_____

_____

_____

What emergency or unusual episode might arise while your child is at our school?_____

_____

_____

What should be done?_____

_____

_____

Name of Hospital_____

*Please complete Step 2 (back of form) if your child's Allergy or Medical treatment could require administrating Epinephrine and/or Antihistamine. Otherwise skip to Step 3 to complete the Action Plan form.

If your child's Allergy or Medical treatment requires any medications, a Medication Authorization form must be completed for each medication and brought to school in a ziplock bag marked with your child's name. These medications MUST be kept in the classroom/or classroom backpack while your child is here at school.

STEP 2: TREATMENT

Symptoms:		**Give checked Medication:**	
*If a food allergen has been ingested, but no symptoms		□Epinephrine	□Antihistamine
*Mouth	Itching, tingling, or swelling of lips, tongue or mouth	□Epinephrine	□Antihistamine
*Skin	Hive, itchy rash, swelling of the face or extremities	□Epinephrine	□Antihistamine
*Gut	Nausea, abdominal cramps, vomiting or diarrhea	□Epinephrine	□Antihistamine
*Throat	Tightening of throat, hoarseness or hacking cough	□Epinephrine	□Antihistamine
*Lung	Shortness of breath, repetitive coughing or wheezing	□Epinephrine	□Antihistamine
*Heart	Thready pulse, low blood pressure, fainting, pale or blueness	□Epinephrine	□ Antihistamine
*Other _____		□Epinephrine	□ Antihistamine
*If reaction is progressing **(several of the above areas affected)**, give		□Epinephrine	□ Antihistamine

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen Jr.® Twinject™ 0.3 mg Twinject ™ 0.15 mg (Our staff is trained in administrating Epinephrine)

Antihistamine: give_____

Other: give_____

STEP 3: EMERGENCY CALLS

Contact Information—please number contacts 1, 2, 3 so our school knows the order in which they should be contacted: 911 will be called **FIRST** if Epinephrine is given or we feel your child's life is in danger. Then we will call the first contact given below.

____Father_____ Daytime Phone_____
(home, work, cell, other)

____Mother_____Daytime Phone_____
(home, work, cell, other)

____Other_____ Daytime Phone_____
Relationship To Child_____ (home, work, cell, other)

*Even if parent/guardian cannot be reached, do not hesitate to medicate or take my child to the medical facility listed.

Parent/Guardian signature_____ Date_____

Physician or licensed health care provider: **(Required)**

Physician's Name(Print)_____Phone_____

Signature_____Date_____

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Medication Authorization

Child's Name:_____

All prescription and non-prescription medications require written authorizations. Each prescription medication must be in the original container, with the directions and label intact. Each non-prescription medication must be in the original container labeled with the child's name. Detailed instruction for administration must be provided.

I Authorize West Des Moines United Methodist Early Learning Preschool to administer the following:

Name of Medication: _____
Amount to be given:_____
Reason to be given: _____
Time to be given: _____
Route to be given: Oral_____ Injection_____ Inhalation_____ Eye_____ Ear_____
Date(s) of authorization: from_____ to _____

Signature of Parent or Guardian_____
Date: _____

Medication	Amount		Date	Time Given	Given By

I picked up my child's medication on the following date:

Signature of Parent or Guardian:_____ Date:_____

Print Name:_____