

**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 for the next school year.

**SETTING UP INFINITE CAMPUS ACCOUNT AT THIS TIME:** As you may know, our preschool partners with the West Des Moines Community Schools (WDMCS) for the prek school year. When enrolling in our Statewide Voluntary Preschool Program, your child also has to enroll with the West Des Moines Community School District in order to track enrollment and attendance. The enrollment process includes the following:

1. Completing the online enrollment process, including creating an Infinite Campus account
2. Choosing your preferred language, then filling out the information and clicking "Begin Enrollment"
3. Completing the demographic information, parent/guardian information, emergency contact, and student information
4. Selecting West Des Moines United Methodist Early Learning Preschool for the community partner preschool option for all four preferences where it asks you to choose your preschool preference
5. Uploading your child's **birth certificate, immunization card, and proof of residency** (i.e. water or utility bill, lease agreement, mortgage, etc.)
6. Reviewing the concussion information, which is required to be shared with all families Prek-12<sup>th</sup> grade

Please use the appropriate link below to complete the process:

1. **New families to WDMCS:** please complete enrollment here:  
<https://campus.wdmcs.org/campus/OLRLoginKiosk/westdesmoines>
2. **Returning families to WDMCS:** please complete enrollment here:  
<https://campus.wdmcs.org/campus/portal/parents/westdesmoines.jsp>

Please contact Alyssa Welling at [wellinga@wdmcs.org](mailto:wellinga@wdmcs.org) if you have questions regarding setting up your Infinite Campus account.

**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

Parent Questionnaire

Allergy and Medical Emergency Action Plan—if we have been informed of an allergy or medical condition for your child. If we have not been notified of an allergy or medical condition for your child, please contact us as soon as possible so that an Action Plan may be mailed to you.

Medical Emergency Action Plan Medication Authorization—if we have an Action Plan that states that medication must be administered as part of the plan

**OTHER ADMISSION REQUIREMENTS:**

1. Children must meet the following age requirement—Statewide Voluntary Preschool Program (SVPP) Classes—children must be 4 years old by September 15, in order to enroll for the 2023-24 school year
2. **A \$75.00 Program Fee is required at this time for SVPP classes—it is non-refundable**

**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.

**STATEWIDE VOLUNTARY PRESCHOOL PROGRAM COST:**

Program Fee		\$75.00
SVPP (4 Year Old) Monthly Tuition Monday/Tuesday/Wednesday/Thursday 8:45-11:45am & 12:30-3:30pm		free*
*monthly tuition is paid with state funding for children who are 4 years old on or before September 15, 2023		
SVPP (5 Year Old) Monthly Tuition Monday/Tuesday/Wednesday/Thursday 8:45-11:45am & 12:30-3:30pm		\$300.00**
**for children who are 5 years old before September 15, 2023		

**Please send the Program Fee 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](mailto:aborness@wdmumc.org) or Teresa Young at the above telephone number or [tyoung@wdmumc.org](mailto: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!

Cordially,



Amy Borness  
Director Of West Des Moines United Methodist Early Learning Preschool



# 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		

# 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.		
Elementary or Secondary School (K-12)	18 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.	
	24 months and older	Measles/Rubella <sup>1</sup>	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 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	3 doses if the applicant received 3 doses before 12 months of age; or 2 doses if the applicant received 2 doses before 12 months of age; or 1 dose if no doses had been received prior to 24 months of age.
24 months and older		Measles/Rubella <sup>1</sup>	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.	

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 5<sup>th</sup> dose of DTaP is not necessary if the 4<sup>th</sup> dose was administered on or after 4 years of age.  
 4 Applicants 7 through 18 years of age who received their 1<sup>st</sup> 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 1<sup>st</sup> 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 acellular pertussis (aP) or cell-free pertussis (CPTV) series, a 4<sup>th</sup> dose is not necessary if the 3<sup>rd</sup> 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 receive the 2<sup>nd</sup> dose if administered 28 days or greater from the 1<sup>st</sup> 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 1<sup>st</sup> and 2<sup>nd</sup> dose of rubella for an applicant 13 years of age or older is 28 days.

**PREK ENROLLMENT FORM**  
**WEST DES MOINES UNITED METHODIST EARLY LEARNING PRESCHOOL**  
**720 GRAND AVE. WEST DES MOINES, IA 50265**  
**515 279-8897**

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 (60 <sup>th</sup> St)	
Mercy One (downtown)	Mercy One West Lakes (60 <sup>th</sup> 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 \_\_\_\_\_  
 Name \_\_\_\_\_  
 Relation to Child \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Work Phone \_\_\_\_\_

City, Zip \_\_\_\_\_  
 Name \_\_\_\_\_  
 Relation to Child \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Employer \_\_\_\_\_  
 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/West Des Moines Community Schools 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.

**PLEASE READ THE FOLLOWING**

Please initial the following statements: This is mandatory for program participants.

\_\_\_\_\_ I give the Preschool Program Administrator permission to obtain and share information about my child's educational progress with school and/or funding personnel.

\_\_\_\_\_ I commit to good attendance for my child and will provide notification if my child will be absent. I understand that failure to do so may result in the loss of funding to pay preschool fees.

\_\_\_\_\_ I will notify the Preschool Program Administrator and the preschool my child is attending, if my phone number or address changes.

**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, 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), Allergy And Medical Emergency Medication Authorization (if applicable), Birth Certificate (required for SVPP Infinite Campus Sign-Up), and Home Language Survey (required for SVPP Infinite Campus Sign-Up) 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 \_\_\_\_\_

**PHYSICIAN'S MEDICAL REPORT**  
**WEST DES MOINES UNITED METHODIST EARLY LEARNING PRESCHOOL**  
 720 Grand Avenue  
 West Des Moines, IA 50265  
 515 279-8897  
 Fax # 515 895-4796

**To be completed by physician**

Name \_\_\_\_\_ DOB \_\_\_\_\_  
 Parent or Guardian \_\_\_\_\_  
 Address \_\_\_\_\_  
 Date Of Exam \_\_\_\_\_

Physical Examination

$\sqrt{\quad}$ = 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 \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone Number \_\_\_\_\_  
 Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

WEST DES MOINES UNITED METHODIST EARLY LEARNING PRESCHOOL  
720 Grand Ave  
West Des Moines, IA 50265  
515-279-8897



PREK PARENT QUESTIONNAIRE

Child's Name \_\_\_\_\_ Date \_\_\_\_\_

We would like to know about your child through your eyes. This will help us to provide your child with a positive learning experience this school year. Please answer the questions below and return to school by July 1<sup>st</sup>.

1. List five words that best describe your child's character.  
Examples...competitive, cheerful, perfectionist, etc.
  
2. List five words that best describe your child's family.  
Examples....home language, culture, religion, race, hobbies, etc.
  
3. How would you describe your child's social skills?  
What social skills in particular would you like to see further developed?





9. List a few things that your child can do independently:

10. What are your parenting approaches to behavior?  
Are there any other family values we should be aware of?

11. Please list any additional resources that can help your family/child to have a successful school year, such as interpreter, Heartland AEA, Social Worker, or any other family/child needs:

12. What special medical needs if any does your child have?

Thank you for taking the time to fill out our questionnaire. Your child's teachers are excited to meet you and your child. You will have the opportunity to set up an "in home" meeting at the Parent Orientation in August. Have a great rest of the summer!!!!

Fondly,  
Amy Borness  
Director of West Des Moines United Methodist Early Learning Preschool

# ALLERGY AND MEDICAL EMERGENCY ACTION PLAN

WEST DES MOINES UNITED METHODIST EARLY LEARNING PRESCHOOL  
720 GRAND AVENUE WEST DES MOINES, IA 50265  
279-8897 Fax # 279-3523  
nsetchell@wdmumc.org or tyoung@wdmumc.org

## STEP 1: CHILD INFORMATION

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_  
Child's Address \_\_\_\_\_ 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? \_\_\_\_\_  
\_\_\_\_\_

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

## STEP 2: TREATMENT

### Symptoms:

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

### Give checked Medication:

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

### DOSAGE

Epinephrine: inject intramuscularly (circle one)      EpiPen®      EpiPen Jr.®      Twinject™ 0.3 mg  
Twinject™ 0.15 mg      (Our staff is trained in administering 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 \_\_\_\_\_ Relationship To Child \_\_\_\_\_  
Daytime Phone \_\_\_\_\_  
(home, work, cell, other)

Name of Hospital \_\_\_\_\_

Physicians Name \_\_\_\_\_ Phone # \_\_\_\_\_

\*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)

Name \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_ Phone \_\_\_\_\_

# Medication Authorization

West Des Moines United Methodist Early Learning Preschool  
720 Grand Ave. West Des Moines, IA 50265 515-279-8897  
Fax#279-3523 nsetchell@wdmumc.org

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. Clear and complete instructions 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: _____ Date(s) of authorization: from _____ to _____  Signature of Parent or Guardian _____ Date: _____
---

Date	Medication	Amount	Time Given	Given By

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

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_