Keokuk Christian Academy
HOME CHURCH SCHOOL

Enrollment Application for Kindergarten through 12th Grade

STUDENT INFORMATION		
Last Name: _____	First Name: _____	Middle Name: _____
Current School: _____	Resident District: _____	County: _____
Birthdate: _____	City: _____	State: _____
Gender: ___Male ___Female	Ethnicity (circle): American Indian Asian Black Hawaiian Hispanic White	
Current or Previous KCA student? (circle) YES NO		
What is the primary language spoken at home? ____ English ____ Spanish Other_____ What is the primary language spoken by the student? ____ English ____ Spanish Other_____ What is the primary language the student first acquired? ____ English ____ Spanish Other_____		

Date of Application: _____

PARENT/GUARDIAN Contact #1		
Last Name: _____	First Name: _____	Cell: _____
Address: _____	City/State: _____	Zip: _____
Email: _____	Work: _____	Work Phone: _____

PARENT/GUARDIAN Contact #2		
Last Name: _____	First Name: _____	Cell: _____
Address: _____	City/State: _____	Zip: _____
Email: _____	Work: _____	Work Phone: _____

EDUCATIONAL/BEHAVIORAL HISTORY	
Has the student attended public school? YES NO	Public School - City/State: _____
Has the student ever been suspended/expelled from school? YES NO Explain reason: _____	
Last Grade Completed: K 1 2 3 4 5 6 7 8 9 10 11	Ever been retained? YES NO Explain: _____

Keokuk Christian Academy
HOME CHRISTIAN SCHOOL

Enrollment Application for Kindergarten through 12th Grade

SPECIAL SERVICES/SPECIAL EDUCATION

Has the student ever participated in any of the following support programs? (circle) YES NO

If yes, please specify: (circle all that apply) Title Reading Title Math IEP 504 Accommodation
ESL/ELL Speech Hearing Other: _____

MEDICAL HISTORY

I understand my child will NOT be allowed to begin school unless I have provided a copy of my child's updated IMMUNIZATION form (OR) I have signed and returned a Religious Exemption form.

Child's Primary Doctor: _____ Address: _____

Does your child have any of the following diagnoses? (Circle all that apply)
ADHD Autism OCD Dyslexia Hearing Loss Other: _____

ALLERGIES

List known allergies here:
_____ _____ _____ _____

DENOMINATIONAL AFFILIATION

My family/child is a member of or attends _____ church

PERMISSIONS

I give my child permission to take part in all activities, (i.e., field trips, etc). YES NO

I give my permission to post my child's name and picture in local newspapers, KCA website, & KCA Facebook page YES NO

Specific Permissions: _____

Keokuk Christian Academy
HOME CHURCH SCHOOL

Enrollment Application for Kindergarten through 12th Grade

STATEMENTS of COOPERATION

1. **I realize it is a privilege for my child to attend Keokuk Christian Academy, and I understand my child may be dismissed from Keokuk Christian Academy at any time if they are found to be out of harmony with the policies set forth by the School Board and as outlined in KCA's Handbook.**

2. **I agree to pay, in full, all fees and tuition according to the agreed upon Tuition Payment Schedule. Not doing so will result in my child being removed from attending Keokuk Christian Academy.**

3. **I understand my child's Enrollment Fee is non-refundable if I should decide to enroll my child elsewhere or transfer my child to another educational setting at any point in the school year.**

4. **I give my child permission to take part in all activities, including off campus field trips, sponsored by KCA throughout the year.**

Parent Signature: _____

Date: _____

Keokuk Christian Academy

HOME CHURCH SCHOOL

Authorization to Dispense Medicine

2026 – 2027

Valid August 1, 2026 through July 31, 2027

In order to dispense **any** medication, even a Tylenol tablet, to a student, the school must have written consent from the child's parent or guardian. It is suggested that you fill in the blanks with prescription medicines as needed, Tylenol, Ibuprofen (please state children or adult strength) and anything else you anticipate your child might take at school. Please be certain that this completed form includes *your signature.* Medication brought to school must be turned in to the office.

I hereby give permission to Keokuk Christian Academy to dispense the following

medication to _____

Student's Name

Medicine **Dosage**

_____

_____

_____

_____

_____

Parent Signature (Please Print)

_____

Parent Signature

1578 Hilton Road, Keokuk, IA 52632 phone (319) 524-5752 FAX (319) 524-1832

"You are the light of the world. A city on a hill cannot be hidden. Neither do people light a lamp and put it under a bowl. Instead, they put it on the stand, and it gives light to everyone in the house. In the same way, let your light shine before men, that they may see your good deeds and praise your Father in heaven." ***Matthew 5:14-16***

MEDIA RELEASE

(Valid August 1, 2026 – July 31, 2027)

Attention Parents and Guardians:

Please fill out the media releases listed below and return it to KCA.

Student(s) Name:_____

_____Yes, _____No, my child's picture may be included in newspapers and other local media for the purpose of advertisement or publicity.

_____Yes, _____No, my child's picture may be included in pictures on the KCA web site.

_____Yes, _____ No, my child's picture may be used on KCA's Facebook page.

_____Yes, _____No, my child's picture may be published in the KCA Yearbook

As always, we will respect your wishes not to have your child's picture included in any or all of our media outlets. You can find our webpage at www.keokukca.com

Parent Signature: _____Date_____

Keokuk Christian Academy

1578 Hilton Road Keokuk, IA 52632

Pick Up Authorization 2026-2027

(Valid August 1, 2026—July 31, 2027)

Child's Name: _____

I hereby give permission for my child to leave Keokuk Christian Academy with the following persons named below. It is the responsibility of the parents to notify Keokuk Christian Academy, in writing, of changes.

Name	Relationship	Contact Number

If there is a separation or divorce custody problem of which we should be aware, please explain.

_____

_____

Name of person who may **not** pick up your child:

_____

Date: _____ Parent Signature: _____

STUDENT VISION CARD

Student First/Last Name _____ Exam Date _____

Student Date of Birth _____/_____/_____ Student Home Zip Code _____

TO THE PARENT OR GUARDIAN: To fully assess the health of your child's visual system and prevent future learning problems associated with undetected vision problems, regular professional eye exams are essential. Experts estimate that 80% of learning is obtained through vision. Good vision directly contributes to a child's ability to learn while in school. As a part of your back-to-school preparations, it is recommended that you take your child and this card to your family eye doctor for a complete eye health examination. **This card should be signed by the eye care professional and returned to the school nurse or teacher by your child.**

Visual Acuity	**At Distance**		**At Near**	
☐ Without correction	R20/	L20/	R20/	L20/
☐ With present correction	R20/	L20/	R20/	L20/
☐ With new correction	R20/	L20/	R20/	L20/

External Eye Health
☐ Normal ☐ Other

Internal Eye Health
☐ Normal ☐ Other

Vision Analysis

R	L			
☐	☐	Normal eyesight	☐	Eye teaming difficulty
☐	☐	Nearsighted (myopia)	☐	Crossed-eyes (strabismus)
☐	☐	Farsighted (hyperopia)	☐	Eye focusing difficulty
☐	☐	Astigmatism	☐	Sensitivity to light
☐	☐	Amblyopia		

☐ Other _____

Vision Correction Recommendations

☐ No correction necessary
☐ No change in present prescription
☐ New prescription needed

To be worn for:
☐ Constant wear ☐ Near vision only
☐ Distance vision only ☐ As needed

TO THE EYE CARE PROFESSIONAL: Please sign and date this card after examination.

Dr. Name: (Please Print) _____

Date_____Signature_____

The following organizations recommend the use of the Student Vision Card

IOWA DEPARTMENT OF EDUCATION

IDPH Iowa Department of Public Health

IOWA OPTOMETRIC ASSOCIATION

Iowa PTA everychild.onevoice.

Prevent Blindness Iowa

To order more cards call 1-800-444-1772 • www.iowaoptometry.org

11/1

STATE OF IOWA
DEPARTMENT OF
Health
AND
Human
SERVICES

CERTIFICATE OF DENTAL SCREENING

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

kindergarten
&
9th Grade
has to have
this done.

Student Information (please print)

Student Last Name:	Student First Name:	Birth Date (M/D/YY):

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 health 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): (Ninth grade screening must be provided by DDS/DMD or RDH.)

☐ DDS/DMD ☐ RDH ☐ MD/DO ☐ PA ☐ RN/ARNP

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 on this form from another health department. 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.

Keokuk Christian Academy

HOME CHURCH SCHOOL

Attached are current medical forms we are required to keep on hand and up to date in accordance with the state of Iowa regulations.

Please have your physician sign and date each form as applicable for your child prior to the start of 2026 school year.

If you have any questions, please contact the office. We appreciate your willingness to help us keep each student as safe as possible.

American Lung Association.

My Asthma Action Plan
For Home and School

Name: _____ DOB: ____ / ____ / _____

Severity Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list): _____

Peak Flow Meter Personal Best: _____

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night
Peak Flow Meter _____ (more than 80% of personal best)

Flu Vaccine—Date received: _____ Next flu vaccine due: _____ COVID19 vaccine—Date received: _____

Control Medicine(s)	Medicine	How much to take	When and how often to take it	Take at
				☐ Home ☐ School
				☐ Home ☐ School

Physical Activity ☐ Use Albuterol/Levalbuterol ____ puffs, 15 minutes before activity ☐ with all activity ☐ when you feel you need it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or tight chest – Problems working or playing – Wake at night
Peak Flow Meter _____ to _____ (between 50% and 79% of personal best)

Quick-relief Medicine(s) ☐ Albuterol/Levalbuterol ____ puffs, every 20 minutes for up to 4 hours as needed
Control Medicine(s) ☐ Continue Green Zone medicines
☐ Add _____ ☐ Change to _____

You should feel better within 20-60 minutes of the quick-relief treatment. If you are getting worse or are in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping
Peak Flow Meter _____ (less than 50% of personal best)

Take Quick-relief Medicine NOW! ☐ Albuterol/Levalbuterol ____ puffs, _____ (how frequently)

Call 911 immediately if the following danger signs are present:
- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

School Staff: Follow the Yellow and Red Zone instructions for the quick-relief medicines according to asthma symptoms.
The only control medicines to be administered in the school are those listed in the Green Zone with a check mark next to "Take at School".

☐ Both the Healthcare Provider and the Parent/Guardian feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Healthcare Provider

Name _____ Date _____ Phone (____) ____ - _____ Signature _____

Parent/Guardian

☐ I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate.
☐ I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medicine.

Name _____ Date _____ Phone (____) ____ - _____ Signature _____

School Nurse

☐ The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Name _____ Date _____ Phone (____) ____ - _____ Signature _____

Please send a signed copy back to the provider listed above.

1-800-LUNGUSA | Lung.org

Emergency Medication Authorization

Attach Child Photo

Child Name: _____ DOB: _____

Child Known Allergies:

Parent/Guardian Permission to give emergency medication:
I give my permission for the early care and education (ECE) program to give the following emergency medication(s) to my child. This permission is for 12 months from my signature date unless revoked:
Parent/Guardian Signature: _____ Date _____

Date:	Name of medication on the label:	Medication dose on the label:	Time (frequency):	Route of medication on the label:	Reason medication needed:	Required storage*: ☐ Refrigerate ☐ Do Not Freeze ☐ Room Temperature ☐ Away from Light
☐ Child's emergency action/care plan has been reviewed and is attached	Possible side effects: (information available at https://medlineplus.gov/druginformation.html)					Medication Expiration Date: _____

*Important! Emergency medications should be stored inaccessible to children but unlocked readily available to supervising caregivers/staff. Emergency medications and child's emergency action/care plan should be available onsite (both indoors and outdoors) as well as during transportation and field trips.

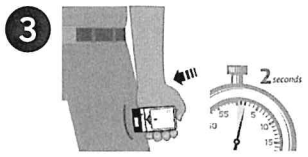
Parent/Guardian Completes Page 1

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

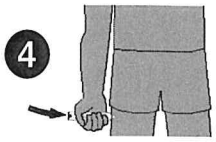
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



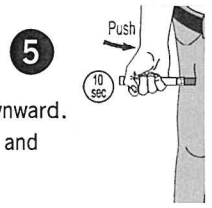
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergic to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

Monthly Medication Authorization

Child Name: _____ DOB: _____ Child Known Allergies: _____ Month: _____ Year: _____

Parent/Guardian Permission to give medication:

I give my permission for the Early Care and Education (ECE) provider/staff to give the following medication to my child.

Date:	Parent/Guardian Signature Giving Permission:	Name of medication on the label:	Medication dose on the label:	Time of day medication is to be given at child care:[1]	Route of medication on the label:	Special instructions for giving medication:[2]	Required storage: ☐ Refrigerate ☐ Do Not Freeze ☐ Room Temperature ☐ Away from Light
Reason medication needed:		Possible side effects: (information available at https://medlineplus.gov/druginformation.html)			Beginning Date: _____ Ending Date: _____ Medication Expiration Date: _____		

Date:	Parent/Guardian Signature Giving Permission:	Name of medication on the label:	Medication ne dose on the label:	Time of day medication is to be given at child care:[1]	Route of medication on the label:	Special instructions for giving medication:[2]	Required storage: ☐ Refrigerate ☐ Do Not Freeze ☐ Room Temperature ☐ Away from Light
Reason medication needed:		Possible side effects: (information available at https://medlineplus.gov/druginformation.html)			Beginning Date: _____ Ending Date: _____ Medication Expiration Date: _____		

Parent/Guardian Permission to Contact Pharmacy and Physician: I give my permission for the ECE provider/staff to contact my child's pharmacy and/or physician should a question arise or a situation occur that involves my child and the medication.

Parent/Guardian Signature: _____ Date: _____

[1] The time of day when the medication is given needs to be consistent between home, child care, school and other programs where the child spends time. Ask the parent/guardian when the medication is given so doses may be evenly spaced as ordered.

[2] The medication may need to be given before meals, after meals, with food, with a specific liquid (water or milk). All instructions should be written on the medication label or accompanying instructions. When in doubt, call the pharmacy where prescription medication was dispensed.

Monthly Medication Record

Attach Child Photo Here

Child Name: _____ DOB: _____ Child Known Allergies: _____

Month _____ Year _____		Day of Month																												
Medication, Dose and Route ↓	Time of Day ↓	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Example: Amoxicillin 250 mg/5ml, give 5ml orally	10 am	*																														

* Sign your initials in the box showing the medication was given. Use an "**A**" when a child is absent. Use an "**O**" when medication is *not given* for any reason. If not given inform the child's parent/guardian, document in the child's health record the reason the medication was not given and that the parent/guardian was informed.

Instructions for using Medication Record:

- First Column: Record the medication name, dosage, and route.
- Second Column: Record the time(s) of day the medication is to be given at child care. If the medication is given more than one time a day, use an additional row for each time of day the medication is to be given.
- Day of Month Column: The person who measures and gives the medication must place their initials in the appropriate **row** (for time) and **column** (for date) that the medication was given. Use columns numbered from 1-31 for the date.

Early Care and Education (ECE) provider/staff signature/initials: _____/____ _____/____

_____/____ _____/____ _____/____

_____/____ _____/____ _____/____

Iowa Poison Control Center: 1-800-222-1222

For questions about administering medications contact your local Child Care Nurse Consultant (CCNC) or Healthy Child Care Iowa at https://hhs.iowa.gov/hcci