

Keokuk Christian Preschool

1578 Hilton Road Keokuk, IA 52632

Application for Enrollment 2026-2027

The Enrollment/Supply Fee is non-refundable

Please mark your session preference:

4 Year-Olds: M-F all day session: _____
M-F morning session: _____

3 Year-Olds: M-W-F morning session: _____

Student Name: _____
Last First Middle

Student's Date of Birth: _____ Sex: _____

Parent of Legal Guardian Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Father's Employer: _____ Phone: _____

Mother's Employer: _____ Phone: _____

Physician's Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Whom to notify if parents cannot be reached:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Family History:

Marital Status of Parents: (Circle One) Married Divorced Separated Deceased Single

Other Children in the Home (Name and Birth Date)

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Church you attend: _____

Date: _____ Parent Signature: _____

Intake Information

Physical Regime

Does your child have any unusual eating problems or food dislikes? (Explain)

What is your child's usual bedtime _____ Usual wake time? _____

What is your child's attitude toward going to bed and taking a nap? _____

How does he state need? Urination Bowel Movement

Play and Sociality

How does he get along with children? _____

Are his playmates: girls? _____ boys? _____ younger? _____ older? _____ none? _____

What is the usual size of the neighborhood play group? _____

Previous group experience? Nursery School? _____ Play group? _____ Sunday School? _____

Personality and Emotional Development

Do you regard your child as affectionate? _____ To whom? _____

Does he accept new people easily? _____

What are your child's fears? _____

Is he usually happy? _____

What nervous habits does he have? _____

When does he show them? _____

When you find it necessary to discipline your child, which parent usually does this and how? _____

Give further information which you believe will be helpful to us in understanding your child. (In case of developmental delays — please describe.)

Do you consider your child to be: right handed _____ left handed _____ not sure _____

CHILD IDENTIFICATION CARD

Child's Name

Date of Birth

Parent/Guardian Name

Home Phone

Cell Phone

Work Phone

Street Address

City

State

Zip Code

Parent/Guardian Name

Home Phone

Cell Phone

Work Phone

Street Address

City

State

Zip Code

Authorized Emergency Contact Name

Phone Number

Authorized Emergency Contact Name

Phone Number

Authorized Out-of-Area Emergency Contact Name

Phone Number

Child's Physician

Phone Number

Keokuk Christian Preschool Karen Swinderman 319-524-5752
Child Care Program Name Owner/Director Name Phone Number

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Parental Emergency Medical & Dental Care Consent

(valid August 1, 2026—July 31, 2027)

Child's Full Name: _____ Date of Birth: _____

Permission for medical and dental care in parental absence.

In the event my child may require emergency dental, medical and/or surgical care while I am out of town or unable to be reached, I hereby give my consent to provide emergency dental, medical and/or surgical treatment to the following:

_____ Hospital

_____ Doctor or his/her designee

_____ Dentist or his/her designee

Insurance: _____ Dental Insurance: _____

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

Parent Signature: _____ Date: _____

Name of Parent or Legal Guardian: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Doctor: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Dentist: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Person to be contacted in case of emergency if parents are unavailable:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Known Allergies: _____ Date of Last Tetanus: _____

Present Medications: _____

Are there any custody or restraining orders for person(s) who may attempt to pick up or have contact with the child while at the center? Yes No If yes, please provide names of anyone who may not pick up or have contact with your child.

Name: _____ Name: _____

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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 | Name | Relationship |
|-------|--------------|-------|--------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

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: _____

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Travel & Activity Authorization 2026-2027

(valid August 1, 2026—July 31, 2027)

Child's Name: _____

I do give my permission for my child to leave the above-named facility for trips in a car or on public transportation to special places, walks to the park, shopping trips, etc. I understand that I will be notified before each such activity.

Restrictions on such trips:

- 1. Each child under six years of age will be secured in a child restraint system (a safety seat or booster seat) for any field trip (other than a field trip on a bus or school bus).*
- 2.*
- 3.*

Date: _____

Parent Signature: _____

Media Release 2026-2027

(valid August 1, 2026 — July 31, 2027)

_____ *Yes, I hereby do give my permission to let my child be photographed for use by the above –named center in the yearbook and newspapers or other media for the purpose of publicity or advertisement.*

_____ *Yes, I hereby do give my permission to let my child be included on the KCA web site.*

_____ *Yes, I hereby do give my permission to let my child's picture be used on KCA's Facebook page.*

Date: _____

Parent Signature: _____

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Iowa Child Care Infant, Toddler, Preschool Age — Child Health Exam Form

HEALTH PROFESSIONAL COMPLETE THIS PAGE

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:

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:

Immunization: may also attach a copy of Iowa Department of Public Health Immunization Certificate.

DtaP/DTP/TD

Hepatitis B

HIB

Influenza

MMR

Pneumococcal

Polio

Varicella

Other

TB testing (only for high risk child)

Medication: health professional authorizes the child may receive the following medications while at child care or preschool: (include over the counter and prescribed)

Medication Name: _____ Dosage _____

_____ Cough Medication

_____ Diaper crème:

_____ 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

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:**

Signature: _____

Circle the Provider Credential Type: MD DO PA ARNP

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.

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.

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

Without correction

With present correction

With new correction

At Distance

R20/

L20/

R20/

L20/

R20/

L20/

At Near

R20/

L20/

R20/

L20/

R20/

L20/

External Eye Health

Normal

Other

Internal Eye Health

Normal

Other

Vision Analysis

R

L

Normal eyesight

Nearsighted (myopia)

Farsighted (hyperopia)

Astigmatism

Amblyopia

Other _____

Eye teaming difficulty

Crossed-eyes (strabismus)

Eye focusing difficulty

Sensitivity to light

Vision Correction Recommendations

No correction necessary

No change in present prescription

New prescription needed

To be worn for:

Constant wear

Distance vision only

Near 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



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