

The Nannies Unlimited Child Center and Preschool Inc.  
6393 NE Rising Sun Drive  
Des Moines, Iowa 50327  
[www.nanniesunlimitedchildcare.com](http://www.nanniesunlimitedchildcare.com)  
515-264-8288

**I. Identification Information:**

**A.** Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

\* If the child does not use his/her legal first name, please list the name he/she will be using:

\_\_\_\_\_

**B. Mother:**

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

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**EMAIL:** \_\_\_\_\_

**C. Father:**

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

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**EMAIL:** \_\_\_\_\_

**D. Guardian or Custodian other than parent: (If Applicable)**

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

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

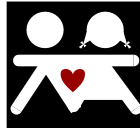
Place of Employment: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**E. Babysitter: (If Applicable)**

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

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Phone Number: \_\_\_\_\_



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**II. Family History:**

Marital Status of Parents: Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_  
Single \_\_\_\_\_ Deceased \_\_\_\_\_

Other children in the home: (Name and birth date)

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**III. Physical Regime:**

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

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What is your child's usual bed time? \_\_\_\_\_ Usual waking time? \_\_\_\_\_

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

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Urination:

Bowel Movement:

How does he/she state need? \_\_\_\_\_;

How Dependable is he/she? \_\_\_\_\_;

**IV. Play and Sociality:**

How does he/she get along with children: \_\_\_\_\_

Are his/her playmates Girls? \_\_\_\_\_ Boys \_\_\_\_\_ Younger \_\_\_\_\_ Older \_\_\_\_\_ None: \_\_\_\_\_

What is their usual size of neighborhood play group? \_\_\_\_\_

Previous group experience: Nursery School \_\_\_\_\_ Play Group \_\_\_\_\_

Sunday School: \_\_\_\_\_

**V. Personality and Emotional Development:**

Do you regard your child as affectionate? \_\_\_\_\_ To Whom? \_\_\_\_\_

Does he/she accept new people easily? \_\_\_\_\_

What are his/her fears? \_\_\_\_\_

Is he/she usually happy? \_\_\_\_\_

What nervous habits does he/she have? \_\_\_\_\_

When does he/she show them? \_\_\_\_\_

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

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VI. Give any further information which you believe will be helpful to us in understanding your child.  
(In case of a handicap-please describe).

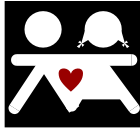
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VII. Do you consider your child to be:

Right-Handed \_\_\_\_\_ Left Handed \_\_\_\_\_ Not sure: \_\_\_\_\_



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## MEDICATION RELEASE

Child's full name: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Please give the above medication:

Amount: \_\_\_\_\_

Time: \_\_\_\_\_

Number of days: \_\_\_\_\_

Or

Number of doses: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_

(Signature)

Date: \_\_\_\_\_

**~ACKNOWLEDGEMENT SIGNATURE ONLY~**



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**Child's Name:**                      **Birthdate:**                      **Present Medication:**                      **Known Allergies:**

\_\_\_\_\_

Short Medical History or problems: \_\_\_\_\_

\_\_\_\_\_

Date of last tetanus: \_\_\_\_\_

Religious preference: \_\_\_\_\_

Insurance : \_\_\_\_\_

\_\_\_\_\_  
Father's Signature:                      Date

\_\_\_\_\_  
Father's Social Security Number:

\_\_\_\_\_  
Mother's Signature:                      Date

\_\_\_\_\_  
Mother's Social Security Number:

**\*Every effort will be made to notify parents (guardian) immediately in case of emergency.**



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**PARENTAL EMERGENCY MEDICAL CONSENT**

Permission for medical care in parental absence.  
 (This form must be presented upon admission for treatment.)

CHILD'S FULL NAME: \_\_\_\_\_

In the event that my child may require emergency medical and/or surgical care while I am out of the city or unable to be reached. I hereby give my consent to medical and/or surgical treatment to the \_\_\_\_\_ and doctor \_\_\_\_\_ or his or her designee to provide this care. I agree to pay all the costs and fees contingent on any emergency medical care and/or treatment for my child as secured or authorized under this consent.

\*Name of parent or legal guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: (\_\_\_\_)-\_\_\_\_\_ Work Phone: (\_\_\_\_)-\_\_\_\_\_

Doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Hospital or preference: \_\_\_\_\_

Person(s) to be contacted in emergency if parents are unavailable:

<u>Name:</u>	<u>Work Phone:</u>	<u>Home Phone:</u>	<u>Relationship:</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

This consent will be in effect beginning \_\_\_\_\_ and continuing while this child is enrolled in this child care facility.



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**PARENTAL EMERGENCY DENTAL CONSENT**

Permission for dental care in parental absence.  
(This form must be presented upon admission for treatment.)

CHILD'S FULL NAME: \_\_\_\_\_

In the event that my child may require emergency dental care while I am out of the city or unable to be reached. I hereby give my consent to the dentist \_\_\_\_\_ dentist office telephone number \_\_\_\_\_ or his or her designee to provide this care. I agree to pay all the costs and fees contingent on any emergency medical care and/or treatment for my child as secured or authorized under this consent.

\*Name of parent or legal guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: (\_\_\_\_)-\_\_\_\_\_ Work Phone: (\_\_\_\_)-\_\_\_\_\_

Dentist: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Hospital or preference: \_\_\_\_\_

Person(s) to be contacted in emergency if parents are unavailable:

Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

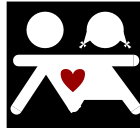
\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

This consent will be in effect beginning \_\_\_\_\_ and continuing while this child is enrolled in this child care facility.



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**PICK UP PERMISSION FORM:**

CHILD'S FULL NAME: \_\_\_\_\_

I hereby give permission for my child to leave the Center with the following person(s) named below. It is the responsibility of the parent(s) (guardian) to notify the Center in writing of any changes.

**~PLEASE INCLUDE PHONE NUMBERS~**

<u>Name:</u>	<u>Phone Number</u>	<u>Relationship</u>
_____	_____	<b>FATHER</b>
_____	_____	<b>MOTHER:</b>
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	

(Date)

(Signature of Parent or Guardian)

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

\_\_\_\_\_  
\_\_\_\_\_

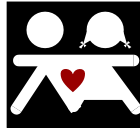
Names of persons who may **NOT** pick up the child (**please provide court papers**)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Name)

(Relationship)





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## PICTURE RELEASE

I hereby **do / do not** **(circle one)** give my consent to let my child be photographed for use by The Nannies Unlimited Child Center & Preschool Inc. in newspapers or other media for the purpose of publicity or advertisements.

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(Signature of Parent/Guardian)

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(Date)



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## TRAVEL AND ACTIVITY AUTHORIZATION

I **Do / Do Not** **(Circle One)** give 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, field trips etc... I understand that I will be notified before each such activity.

Restrictions on such trips:

1. Children ages 3 up to 6 will be secured in a child restraint system (a safety seat or booster seat - NOT a seat belt).
2. Children from the age of 6 up to the age of 11 will be secured in a child restraint system or by a safety belt.

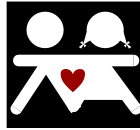
\*Additional restrictions, if any, set by parent(s)/guardian(s)

3. \_\_\_\_\_

4. \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date



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## ACKNOWLEDGMENT FORM

We hereby acknowledge that we have received, read, understand and will follow the policies and procedures set forward in The Nannies Unlimited Child Center & Preschool Inc.'s parent manual.

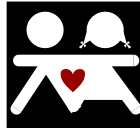
We understand that this contract can be terminated at any time for any reason(s)

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(Signature of Parent/Guardian)

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(Date)



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## **CONTRACT AGREEMENT**

\_\_\_\_\_ Parent(s) of \_\_\_\_\_  
do hereby agree to pay, The Nannies Unlimited Child Center & Preschool Inc.  
\_\_\_\_\_ dollars, weekly, starting \_\_\_\_\_. All fees must be paid by  
Monday of the week prior to attendance. \_\_\_\_\_

The child's first week of tuition and a non-refundable registration fee of \$75.00/child shall be paid upon enrollment (re-enrollment) and/or securing a child's position at the Center (earnest money). A non-refundable re-registration fee of \$35.00/child will be collected annually.

You must pay for the full week even if your child misses a day whether it is due to illness, or they are just not attending that week. The Nannies Unlimited Child Center & Preschool Inc. charges by the week. If your child attends one day or five days you will be charged for the entire week, this includes holidays.

If you wish to terminate your child(ren) from The Nannies Unlimited Child Center and Preschool Inc., it is required that you provide administration a two (2) week written notice. If you fail to give The Nannies Unlimited Child Center and Preschool Inc. a two (2) week written notice and fulfill your commitment, you will be responsible for payment (according to your contract agreement) for those two weeks your child(ren) should have attended the Center.

Payment is due every Monday morning unless other arrangements have been made in advance. Outstanding balances shall never exceed one week of day care fees.

All payments will be made with a check (or cash), please make checks out to The Nannies Unlimited Child Center & Preschool Inc. Keep up on payments to avoid problems of dismissing your child until payment is made.

There are penalties for late payments, returned checks, or late pickups:

For the first late payment, (defined as being after Monday at 5:30 p.m.) there is an automatic \$10.00 penalty payable immediately. For the first returning check, there will be an automatic \$20.00 penalty. The returned check and service charges must be paid in cash.

For the second late payment, the child is subject to immediate dismissal from the program. No child will be allowed to attend the program with outstanding bills.

Pick up time for all programs will be by 5:30p.m. if you are late you will be charged \$15 for each additional 15 minutes per child. (For example, 5:31 p.m.- 5:45 p.m., \$15; 5:46-6:00 p.m., \$30 etc.) You will be notified at the time you pick up your child. Payments must be made to the staff. If payment is not received or for repeated late pickups, your child will be subject to dismissal from our program. With my/our signature(s) below I/we agree to follow the above contract.

**Signature:**

**Date:**

\_\_\_\_\_

\_\_\_\_\_



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## Child's Medical Update

I have examined \_\_\_\_\_, or have sufficient ongoing knowledge of his/her medical condition to state this child is free of any communicable or infectious disease and is able to participate in a child care program.

**Restrictions:** Yes \_\_\_\_\_ **(Please explain below)** No \_\_\_\_\_

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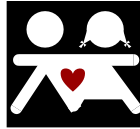
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\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Physician's Address

\_\_\_\_\_  
Date

\*Note: This form is also used for a child entering the program for the second or succeeding years.



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**PHYSICAL EXAMINATION: (to be completed by the physician or designee)**

Child's Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Skin: \_\_\_\_\_ Head/Scalp: \_\_\_\_\_

Eyes: \_\_\_\_\_ Nose: \_\_\_\_\_ Lymph Nodes: \_\_\_\_\_

Ears: \_\_\_\_\_ (L) TM \_\_\_\_\_ (R) TM \_\_\_\_\_

Mouth: Teeth \_\_\_\_\_ Gingiva \_\_\_\_\_ Palate: \_\_\_\_\_

Throat: \_\_\_\_\_ Neck: \_\_\_\_\_ Chest: \_\_\_\_\_

Heart: \_\_\_\_\_ B.P \_\_\_\_\_ Femoral Pulse \_\_\_\_\_

Lungs \_\_\_\_\_ Abdomen: \_\_\_\_\_

Genitalia: \_\_\_\_\_ Rectum/Anus: \_\_\_\_\_

Spine/Back: \_\_\_\_\_ Extremities: \_\_\_\_\_

Neuromuscular: \_\_\_\_\_ Gait: \_\_\_\_\_

Urinalysis: \_\_\_\_\_

Vision: (R) eye \_\_\_\_\_ (L) eye \_\_\_\_\_ Both: \_\_\_\_\_

Hearing: Normal: \_\_\_\_\_ Abnormal: \_\_\_\_\_ Not Tested: \_\_\_\_\_

If needed: Hemoglobin or Hematocrit: \_\_\_\_\_ Tuberculin Screening \_\_\_\_\_

Sickle Cell Screening: \_\_\_\_\_ Development Testing \_\_\_\_\_

Lead Screening: \_\_\_\_\_ Other: \_\_\_\_\_

Allergies: \_\_\_\_\_

Summary of findings and recommendations: I have examined \_\_\_\_\_

He/She is \_\_\_\_\_ is not \_\_\_\_\_ physically and emotionally able to participate in your program.

Additional Comments:

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Date of the physical examination: \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician or Designee

\_\_\_\_\_  
Date

**Parent: Please complete the following:**

Diseases child has had, \_\_\_\_\_

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Any special health needs (susceptible to colds, recurrent ear infections etc... )

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**\* Please remember the immunization record attached or provide us with a current copy.**