Holt High School

“Holt’s Hut” Child Development Center

Operational Guidelines 2018-19

- Holt High School welcomes children ages 3-5 years old who are potty training and properly immunized to enroll in “Holt’s Hut” preschool center.

- The Holt’s Hut will be in session at HHS on Tuesday, Thursday, and Friday mornings (unless otherwise noted) from 9:15 until 10:45. Please be punctual in bringing your child to school and in picking them up. The high school students put into practice their childcare skills in this program and preschool attendance is necessary for their learning.

- Please return all forms to Hali Hill, HHS Child Development teacher, by August 31st 2018.

- The fee is $75 per semester, this is less than $3 a day! Please pay up front for the semester. Please make checks out to Holt High School, cash is also accepted.

- If you have any further questions please email Hali Hill at halihill@wsdr4.org

Holt High School
Child Development Center

Immunization Verification

Child's Name (Please Print): _____

Birthdate: _____ / _____ / _____

Are the child's immunization in compliance with the state law? YES NO
(A copy of the preschool immunization requirements is included with this form.)

Printed Physician Name: _____

Physician's Phone Number: _____

Please include a current copy of the child's Immunization Records to this form and return it to HHS care of Ms. Hali Hill.

Missouri Child Care and Preschool Immunization Requirements Screening Tool

*Many Missouri children receive vaccines based on the **recommended** schedule from the Advisory Committee on Immunization Practices (ACIP), ensuring that children are well protected against vaccine-preventable diseases. This chart is a **basic screening tool** for child care providers to determine which vaccines children in care need to have in order to be in compliance with state immunization **requirements**. There may be some additional spacing requirements not included on this **basic screening tool**.*

STEP 1: Determine child's age.

STEP 2: Review the immunization requirements for the child's age.

STEP 3: Count the number of doses required for each vaccine category.

STEP 4: Check dose and spacing on children **19 months and older.**

STEP 5: If a Parent/Guardian Exemption is on file; ensure it reflects the current year.

STEP 6: If an In progress card is on file, check the due date for the next dose. Due to the spacing requirements of the vaccine series, this appointment must be kept. If the appointment is **not** kept the child is no longer in progress and is noncompliant.

VACCINES REQUIRED FOR CHILD CARE AND PRESCHOOL ATTENDANCE	DOSES REQUIRED BY THE TIME THE CHILD IS				SPACING REQUIREMENTS If the vaccine is given 4 days early, the child is considered adequately immunized.
	3 MONTHS	5 MONTHS	7 MONTHS	19 MONTHS AND OLDER	
DTaP/DT	1	2	3	4	At least 6 months between doses 3 and 4.
IPV (Polio)	1	2	2	3	
Hib	1	1	2	3 → 2 → 1 →	• 3 doses with final dose on or after 12 months of age; or • 2 doses with 1 dose on or after 15 months of age; or • 1 dose on or after 15 months of age; or • If the current age is **5 years** or older, no new or additional doses are required.
Hepatitis B	1	2	2	3	• Last dose must be on or after 24 weeks (6 months) of age.
PCV (Pneumococcal Conjugate, Prevnar)	1	2	3	4 → 3 → 2 → 1 →	• 4 doses with dose 4 on or after 12 months of age; or • 3 doses with 1 dose on or after 12 months of age; or • 2 doses on or after 12 months of age; or • 1 dose on or after 24 months of age; or • If the current age is **5 years** or older, no new or additional doses are required.
MMR				1	• MUST be given on or after 12 months of age.
Varicella				1	• MUST be given on or after 12 months of age. • For proof of varicella disease, a written statement from a licensed healthcare provider must be on file.

Wentzville R-IV School District

Dr. Curtis Cain
Superintendent of Schools

"Learning Today, Leading Tomorrow"

PARENTS RELEASE TO SCHOOL

Student Name: _____

I hereby state that I have read and fully understand the rules and regulations regarding the giving of any type of medicine to my child during school hours. I agree to abide by these regulations. I also agree as indicated by signature below to release the District and/or all District personnel from liability for any and all injuries that may result from my child taking or neglecting to take medicine prescribed.

In addition, I agree to the sharing of medical information with school faculty and staff on a need to know basis, including but not limited to medications, diagnosis and physical restrictions or limitations.

Print Parent Name	Parent Signature	Date
Home Phone Number	Emergency Number	Alternate Number
Doctor's Name	Doctor's Phone Number	

EMERGENCY CARE PROCEDURE

In case of critical emergency, the parent or guardian will be contacted first, if possible. The family physician will be used only when the parent cannot be reached. If we are unable to contact the parent, the emergency ambulance service will be utilized.

In a critical emergency (life threatening), I understand that my child will be taken to the closest hospital at the discretion of the emergency medical service (EMS).

I will accept full financial responsibility for charges connected with the use of an ambulance and for charges connected with care at the hospital.

Print Parent Name	Parent Signature	Date

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STUDENT HEALTH INVENTORY

Date _____ Grade _____

Child's Name _____ Date of Birth _____ Sex _____

Local Physician's Name _____ Physician's Address _____ Physician's Telephone _____

Does Your Child Have:				Treating Physician
Allergies	No	Yes	Specify_____	_____
Asthma	No	Yes	Specify_____	_____
Diabetes	No	Yes	Specify_____	_____
Epilepsy/Seizures	No	Yes	Specify_____	_____
Heart Condition	No	Yes	Specify_____	_____
Orthopedic Problems	No	Yes	Specify_____	_____
ADD/ADHD	No	Yes	Specify_____	_____
Mental Health Cond.	No	Yes	Specify_____	_____

Has Your Child Had:

Serious Illness No Yes Specify_____

Does Your Child:					
Have trouble seeing close work	No	Yes	Seeing at a distance	No	Yes
Wear glasses	No	Yes	Wear contact lenses	No	Yes
Have trouble hearing	No	Yes	Wear a hearing aid	No	Yes
Have a condition which prevents participating in regular P.E.	No	Yes	Specify_____		
Severe nose bleeds	No	Yes	Comments_____		

Has Your Child Had the Disease (State Approximate Age):

Chicken Pox	No	Yes	Rheumatic Fever	No	Yes
Measles (Hard)	No	Yes	Other_____		
Measles (3 Day)	No	Yes	Other_____		
Mumps	No	Yes			

MEDICAL HISTORY

1. Child currently has health problems: Yes No If yes, explain briefly:

   _____

2. Child currently taking medication: Yes No If yes, list medicine(s):

   _____

   Please read and follow the Medication at School policy.

3. Record of Accidents/Hospitalizations/Surgeries:

Accident/Hospitalization/Surgery	Date	Examiner	Findings
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Signature of Parent of Guardian_____

Reviewed 12/13/2013

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Student's Full name: _____ Nickname: _____
Date of Birth: _____ Current Age:_____
Gender:_____ Potty Trained: Yes No In Progress

Allergies:_____

Primary Caregivers

Name:	Name:
Relationship:	Relationship:
Address:	Address:
Email:	Email:
Daytime Phone:	Daytime Phone:

Child lives with

Plans to attend on: Tuesday Thursdays Fridays

Permission to Pick Up Granted To:

1. Name:
   Relationship:
   Phone:
2. Name:
   Relationship:
   Phone:
3. Name:
   Relationship:
   Phone:
4. Name:
   Relationship:
   Phone:

Student's Interest:

Favorite Snacks:

Mt student is skilled at:

My Student Struggles with:

Permission granted for this child's photo to be taken and posted on school related social media accounts: YES NO