



320 East College Street
Iowa City, Iowa 52240
Phone: 337-3333
Email: kidscarecoop@yahoo.com

Kids Care Cooperative General Information

Purpose

Kids Care Coop is a parent-supervised, non-structured play environment for children ages eight months to five years. Special accommodations are made for children two months to eight months. It is a great place for kids to learn how to get along with others and make friends. It is also a great place for mothers and fathers to make friends!

Organization

Kids Care Coop is a state-licensed, non-profit child-care center. We are an all-volunteer run cooperative serving up to approximately twenty families. Member parents share the responsibilities of child care supervision, support the Coop financially, and help maintain the facilities and the cooperative. Member parents also have voting rights in establishing Kids Care Coop goals and policies. To fulfill state requirements of all licensed daycare workers, member parents must become CPR and First Aid certified, and complete their Mandatory Reporting of Child Abuse and Universal Precautions of Infectious Diseases (UP) classes within the first six months of starting work.

General Information

Kids Care Coop is open 9:00 a.m. to 11:30 a.m., Monday through Friday. Child pickup is by 11:30 a.m. We are closed on Iowa City school holidays and snow days throughout the year. Depending on member preference we may close for some of the summer break.

Operation

As members, parents earn mornings of child care by working at Kids Care Coop. Members have the option of working once a week (as a "Regular") or once every two weeks (as an "Alternate"). Members earn four mornings of child care for each morning of work (although the system depends upon parents not using all of their mornings of child care every week).

Enrollment

Kids Care Coop is licensed to care for twelve children each day at a ratio of one parent worker to four children. Each day spaces are filled on a first-come, first-served basis. Parents earn the right to reserve one space for their child(ren) for each shift worked.

Facilities

Kids Care Cooperative rents space from Trinity Episcopal Church and shares the facility with the church nursery on Sundays. The Coop owns a large collection of developmentally appropriate toys, books, games, play equipment, and a variety of art supplies.

Monthly Dues and Snack Fees

Regular membership/one child: \$16 + \$5 snack fee	Alternate/one child: \$10 + \$2.50
Regular membership/two children: \$18 + \$5 snack fee	Alternate/two children: \$12 + \$2.50

Application/Orientation

Attached is our application packet. Once you've completed it, mail or drop it off at the Coop along with the \$10.00 application fee and the \$30.25 state and federal background check fee. When we receive your application, we will call and schedule your orientation.



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Working Member Information Record

Full Name

Email Address

Full Address

Home Telephone #

Cell Phone #

Child(ren) Name(s)

Child(ren) Birth Date(s)

Educational Background: _____

Current Employment & Employer: _____

Brief statement of experience working with children:

Note any child care/development courses or training:

If you have school-aged children that may accompany you please ask for a School-Age Child Health Form at Orientation. This form and a copy of your child's immunization certificate must be in their file for them to attend Kids Care Cooperative with you on your working days.

Child(ren) Name(s)

Birth Date(s)

State Information:

I have never been convicted by any law of any state for lascivious acts with a child, child neglect, or child abuse.

Date of Application

Applicant's Signature



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Parental Emergency Medical Consent for Kids Care Cooperative

This form must be presented upon admission for treatment.

Child's Full Name: Date of Birth:

This form allows parents and guardians to authorize the provision of emergency treatment for above named child who becomes ill or injured while under program authority when parents or guardians cannot be reached.

In the event reasonable attempts to contact me at (phone #) or (phone #) are unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by Doctor (physician) at (phone #) or Doctor (dentist) at (phone #), or in the event the designated practitioners are not available, then by another licensed physician or dentist; and the transfer of the child to (preferred hospital). I agree to pay all the costs and fees contingent on any medical care and treatment for my child as secured or authorized under this consent.

1. Parents/Guardians/Custodians with whom the child resides:

- Name: Relationship to Child:
Address: Home Phone:
Employer: Department:
Work Phone: Work Hours:
Name: Relationship to Child:
Address: Home Phone:
Employer: Department:
Work Phone: Work Hours:

2. Two persons to contact and are authorized to pick up child in case of emergency if parents are unavailable:

- Name: Relationship to Child:
Address: Home Phone:
Employer: Department:
Work Phone: Work Hours:
Name: Relationship to Child:
Address: Home Phone:
Employer: Department:
Work Phone: Work Hours:

3. Are there any custody or restraining orders for person(s) who may attempt to pick up or have contact with the child while in care at the center? • Names:

4. Medical Information:

Child's Doctor Phone # Street Address City

Child or Family Dentist Phone # Street Address City

Date of Last Tetanus Known Allergies Present Medication

Insurance Company: Policy Holder's I.D.:

This consent will be in effect for one year beginning (date)

Signature Parent/Guardian Date Signature Parent/Guardian Date



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Background Check Information:

Because we are a state-licensed playgroup, we run two background checks on working members. One is with the state where we need your first, middle, last, and maiden name, date of birth and social security number if you have one and it costs \$15. The other is with the federal government where we send in your fingerprint card and costs \$15.25.

After you return your application packet or at your orientation, you will receive your fingerprint card and will need to get that completed. Below are the places that do fingerprinting and their specifics. Please complete all your personal information and our playgroup specific information:

- In the box that says:
 - Your no OCA write “DC309”
 - Reason Fingerprinting write “NCPA/VCA Volunteer”

Where to get fingerprinted:

- University of Iowa Police
 - The University Police provide fingerprinting services to University of Iowa faculty, staff, students and spouses for \$10.
 - Bring your fingerprint card **but** do not fill them out until after you are fingerprinted – they use a printer to complete the prints
 - The hours of fingerprinting are:
 - Mon-Tues: 10:30 am - 6:00 pm
 - Wed-Fri: 9:00 am - 4:30 pm
 - Phone: (319) 335-5022
 - Address: Old Capital Mall Basement
 - 808 University Capital Centre, 200 S. Capitol Street, Iowa City, IA 52242-5500
 - Use the elevator by the parking ramp connected to the Mall to go to the basement.
- 4C's
 - Fingerprinting by appointment with Elizabeth Wallace
 - Cost is around \$5
 - Call (319) 338-7684 or email: elizabeth@iowa4cs.com
 - Address: Near Sycamore Mall: 1500 Sycamore Street, Iowa City, IA 52240
- Johnson County Sheriff
 - Fingerprinting will be done on Tuesdays only (excluding holidays) from 9:00 am to 4:00 pm.
 - A picture ID with name and signature is required.
 - The fee is \$20.00 per applicant (CASH ONLY).
 - You need to be at the Sheriff's Office by 3:45 pm. There may also be a waiting period due to jail operations.
 - Phone: (319) 356-6020
 - Address: 511 S Capital St, Iowa City, IA



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Infant Sleeping Position Authorization

Note: This form must be completed if your child is less than two years old.

While sleeping in a crib at Kids Care Cooperative, I authorize my child _____
(child's name) to be placed on his/her (please circle one)

Back

Stomach

Side

Roll Independently

Parent Signature: _____ Date: _____

Printed Name: _____



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Release from Liability

The undersigned individual, who is the parent or legal guardian of _____
(full name of child), does hereby agree to release the Kids Care Cooperative Playgroup, Trinity
Episcopal Church and all other involved parties from any and all liability associated with the
playgroup experience while the child is attending Kids Care Cooperative.

Signature of Parent or Guardian:

Date:

Year 1:		
Year 2:		
Year 3:		



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Working Member Health Report

Iowa DHS Regulations:

"237A.5 All personnel in licensed centers shall have good health as evidenced by a report following a pre-employment physical examination taken within six months prior to beginning employment, including communicable disease tests, as reported, by a licensed physician. This shall be repeated a minimum of every three years thereafter." (Iowa DHS regulations)

Health Report to be filled out by Working Member's doctor:

I have examined _____ (Working Member) and find this person to be free of any communicable or infectious disease and to be free of any physical or mental condition which would adversely affect the Kids Care Cooperative program or its beneficiaries.

TB Test _____

(Please note: a person who tests positive for tuberculosis should have a statement from the physician indicating whether or not the person is restricted in any manner from providing care. Please make a notation below or attach such a statement.)

Notes: _____

Date of Examination

Physician's Signature

Physician's Telephone #

Physician's Address



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Child Health Report

Iowa DHS Regulations: "109.3(1) The child care center shall require each preschool age child to have an admission physical examination report signed by a licensed physician or designee in a clinic supervised by a licensed physician. This report shall include an immunization record that is in compliance with the Iowa State Health Department regulations. This report shall include past health history, status of present health and recommendations for continued care when necessary. A statement of health condition signed by a physician or designee will be submitted annually thereafter."

Child's Name: _____ Birth Date: _____

Sex: FEMALE MALE Height: _____ Weight: _____

Diseases:	Age:	Diseases:	Age:
Chickenpox	_____	Mumps	_____
Pneumonia	_____	Whooping cough	_____
Measles	_____	Influenza	_____
Asthma	_____	Scarlet Fever	_____

Other illnesses: _____

Operations: _____

Allergies (including food and drugs): _____

Any regular medications: _____

SUMMARY OF FINDINGS AND RECOMMENDATIONS:

I have examined _____ (child's name) and find that he/she IS / IS NOT physically and emotionally able to participate in Kids Care Cooperative.

Immunizations ARE / ARE NOT complete for age.

Additional comments: _____

Date of next recommended physical examination: _____

Date of Examination

Physician's Signature

Physician's Telephone #

Physician's Address

TO BE COMPLETED BY THE PARENT:

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

***** PLEASE make sure to ask for an immunization record *****



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Mandatory Reporting of Child Abuse

Section 232.69 of the Iowa Code requires that every employee of a licensed day care or preschool facility, who in the course of employment reasonably believes a child has suffered sexual abuse, physical abuse, or denial of critical care, shall immediately notify the Department of Human Services.

Section 232.70 of the Iowa Code requires that each report made by a mandatory reporter, as defined in Section 232.69, shall be made both orally and in writing. The oral report must be made by telephone or otherwise to the Department of Human Services within 24 hours of becoming aware of suspected abuse. If the person making the report has reason to believe that immediate protection for the child is advisable, that person shall also make an oral report to an appropriate law enforcement agency. The written report must be made to the Department of Human Services within forty-eight hours after the oral report.

By law, the oral and written reports shall contain the following information, or as much thereof as the person making the report is able to furnish:

1. The name and home address of the child and his parents or other persons believed to be responsible for his care;
2. The other child's present whereabouts if not the same as the parent's or other person's home address;
3. The child's age;
4. The nature and extent of the child's injuries, including any evidence of previous injuries;
5. The name, age, and condition of other children in the same home;
6. Any other information which the person making the report believes might be helpful in establishing the cause of the injury to the child, the identity of the person or persons responsible for the injury, or in providing assistance to the child; and
7. The name and address of the person making the report.

Legal Sanctions for failure to report are as follows;

1. Any mandatory reporter who knowingly and willfully fails to report a suspected case of child abuse is guilty of a simple misdemeanor.
2. Any mandatory reporter who knowingly and willfully fails to report is civilly liable for the damages proximately caused by such failure (Legal Reference 232.75).

Any mandatory reporter who in good faith makes a report of child abuse or participates in the investigation of a child abuse has immunity from any liability, civil or criminal. Records and/or information pertaining to the abuse may be released to the child abuse investigator without releases required in other situations. (Legal Reference 232.73)

To report child abuse anytime, day or night, call toll-free: **1-800-362-2178**



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School-Aged Child Health Form (To be completed by parent)

Child's Full Name: _____ Birth Date: _____

Parent's Full Name: _____

Health Statement:

List any significant illnesses and surgeries that your child has had and their age at the time:

Does your child have any special health-related needs (allergies, medications, injuries, etc.)? If yes, please list: _____

Physical Assessment:

Is there any defect of vision, hearing or speech of which the child care program should be aware, or could compensate by appropriate action? _____

Is this child subject to any conditions which limit classroom activities or physical education? If yes, please list: _____

Is this child subject to any condition which may result in an emergency situation? If yes, please list: _____

Is this child subject to any mental or physical condition for which he/she should remain under periodic medical observation? _____

Is there any other information you would like to share? _____

Parent Signature: _____ Date: _____



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Membership Requirements

Please review the following requirements and sign the statement below indicating that you understand our requirements for membership to the Kids Care Cooperative.

- Submit all required paperwork:
 - \$10 Application Fee
 - Date: _____ ○ Working Member Information Record (*Update as changes occur*)
 - Date: _____ ○ Parental Emergency Medical Consent (*Update as changes occur or annually*)
 - Date: _____ ○ State Background Check Information and \$15 fee (*Update every two years*)
 - Date: _____ ○ Fingerprints and \$15.25 fee (*Update every two years*)
 - Infant Sleeping Position if child is under two (*Update annually*)
 - Date: _____ ○ Release from Liability (*Update annually*)
 - Date: _____ ○ Working Member Health Report (*Update every three years*)
 - Date: _____ ○ Child Health Report (*Update as changes occur or annually for older children*)
 - Date: _____ ○ Child Immunization Form (*Update as changes occur or annually for older children*)
 - Date: _____ ○ Membership Requirements (*Update annually*)
 - Date: _____ ○ Employee Statements (*Update every two years*)
 - Pick-up Permission Form if necessary (*Update as changes occur*)
 - Attend an orientation session, as a new applicant, prior to the first day of work.

- Within the first 6 months of starting work, you must:
 - Become certified in **First Aid** (*Renew every 2 years*)
 - Become certified in **Adult/Child CPR** (*Renew every 2 years*)
 - Take **Mandatory Child Abuse Reporting** class. (*Renew every five years*)
 - Take **Universal Precautions Against Infectious Diseases** class. (*Renew annually*)

- Each year members must:
 - Acquire at least five hours of additional In-Service Training annually (four hours each year after your first year) related to preschool, child care and development. Record dates and hours on your professional growth record file. (May be fulfilled by attending sponsored In-Service Training sessions or attending seminars.)
 - Sign up for a Cooperative job – and do the required work consistently.
 - Sign up for a Cleaning job – and do the required work consistently.

- Additional Requirements:
 - Arrive at Kids Care at 8:45 on the mornings you work.
 - Wear the Kids Care Cooperative t-shirt on your work day – costs \$15.
 - Pay dues during the first week of each month.

I understand that as a member of Kids Care Cooperative, I am required to complete and maintain the training and paperwork listed above. If I do not fulfill these requirements, I will not be allowed to work at the Coop and will be removed from the schedule until I do fulfill these requirements. I will record all completed training on my Member Records sheet at least three times a year and will provide copies of my training certifications in a timely manner.

Member Signature: _____ Date: _____

Member received copy: _____ Anticipated Start Date: _____



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Employee Statements

Name: _____ Employment Date: _____

I (check one) **DO** **DO NOT** have any criminal convictions (to include deferred judgments, even if discharged) of any law in any state.
(If “**DO**” is checked, briefly explain the circumstances.)

I (check one) **DO** **DO NOT** have any founded or confirmed reports of child or adult abuse or neglect in any state.
(If “**DO**” is checked, briefly explain the circumstances.)

I (check one) **DO** **DO NOT** have any communicable diseases or health concerns that would pose a threat to the health, safety, or well-being of the children.
(If “**DO**” is checked, briefly explain the circumstances.)

I (check one) **HAVE** **HAVE NOT** been informed of my responsibilities as a mandatory reporter of child abuse.

I (check one) **AM** **AM NOT** under the influence of alcohol, illegal drugs, prescription or nonprescription drugs that could impair driving ability.

Signature of Employee:

Date:

Year 1:		
Year 2:		
Year 3:		



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Pick-Up Permission Form

Please list persons on this form who will be allowed to pick up your child from Kids Care Coop. Written permission must be obtained before a child will be allowed to leave with any person other than the parents or legal guardian.

I hereby give permission for my child, _____, to leave Kids Care Coop with the persons listed below. I understand it is my responsibility to notify Kids Care Coop in writing of any changes to this list.

Name	Relationship to Child	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If there is a custody situation that we should be aware of, please explain:

Name of person who is ordered by court NOT to pick up your child:

Parent/Guardian Signature _____ Date _____



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Field Trip Consent:

I, the undersigned, consent to the participation of my child in occasional educational trips for one year from the date specified below. I release Kids Care Cooperative, its officers and workers, when exercising due care, from any liability for injury suffered by the named student in transit to and from and at such activity.

	Child's Name	Parent/Guardian's Signature	Date
Year 1:			
Year 2:			
Year 3:			

Sunscreen Application Consent:

I, the undersigned, consent to allow Kids Care Cooperative, its officers and workers to apply sunscreen to my child for one year from the date specified below. I release Kids Care Cooperative, its officers and workers, when exercising due care, from any liability for injury suffered by the named child.

	Child's Name	Parent/Guardian's Signature	Date
Year 1:			
Year 2:			
Year 3:			



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, 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		Vaccine	Date Given	Doctor / Clinic / Source
Diphtheria, Tetanus, Pertussis <i>DTaP/DTP/DT/Td/Tdap</i>				Meningococcal <i>MCV4/MPSV4</i>			
Polio <i>IPV/OPV</i>				Hepatitis A			
Measles, Mumps, Rubella <i>MMR</i>				Rotavirus			
Haemophilus influenzae type b <i>Hib</i>				HPV			
Hepatitis B				Licensed Child Care Requirements			
				<u>2 through 5 months</u>		<u>6 through 14 months</u>	
				1 dose Diphtheria/Tetanus/Pertussis	2 doses Diphtheria/Tetanus/Pertussis	2 doses Polio	2 doses Hib
				1 dose Polio	2 doses Polio	2 doses Hib	
Varicella Chicken Pox If applicant has a history of natural disease write "Immune to Varicella"				<u>15 through 18 months</u>		<u>19 months and older</u>	
				3 doses Diphtheria/Tetanus/Pertussis	3 doses Diphtheria/Tetanus/Pertussis	3 doses Polio	3 doses Polio
				3 doses Hib with the final dose \geq 12 months of age, or 1 dose \geq 15 months of age	3 doses Hib with the final dose \geq 12 months of age, or 1 dose \geq 15 months of age	1 dose Measles/Rubella \geq 12 months of age	1 dose Varicella \geq 12 months of age if born on or after September 15, 1997, or a reliable history of natural disease
				1 dose Measles/Rubella \geq 12 months of age	1 dose Measles/Rubella \geq 12 months of age	1 dose Varicella \geq 12 months of age if born on or after September 15, 1997, or a reliable history of natural disease	
Pneumococcal <i>PCV/PPV</i>				Elementary/Secondary School Requirements			
				<u>4 years of age and older</u>			
				4 doses Diphtheria/Tetanus/Pertussis if born after September 15, 2000; or 3 doses if born on or before September 15, 2000. One of these doses must be received \geq 4 years of age.			
				3 doses Polio, with 1 dose \geq 4 years of age.			
			2 doses Measles/Rubella or positive antibody test for measles and rubella. First dose \geq 12 months of age; second dose no less than 28 days after the first dose				
			3 doses Hepatitis B if born on or after July 1, 1994				
			1 dose Varicella \geq 12 months of age if born on or after September 15, 1997, or a reliable history of natural disease				

**STATE OF IOWA
DHS CRIMINAL HISTORY RECORD CHECK
FORM B**

PURPOSE: Child Day Care 237A.5, 237A.20 Adoption 600.8(1)(2) Child Abuse 232.71
 Foster Care/Group Foster Care 237.8 Institutions/Facility 218.13 Juvenile Homes 232.142

REQUEST

<i>Center Name and Mailing Address</i>

I am requesting an Iowa Criminal History (CCH) check on:

Last Name	First Name	Middle Name
Maiden/Former Name, any Alias (<i>List All</i>)	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Social Security Number
Date of Birth	Signature of Requester	

DO NOT WRITE IN THIS AREA – FOR DCI USE ONLY

RESULTS

As of _____ (date) a name and date of birth check revealed:

_____ CCH record attached _____ No CCH record found

DCI Initials _____

WAIVER
(see reverse side)

I hereby give permission for the above requesting official to conduct an Iowa criminal history check with the Division of Criminal Investigation. Any information maintained by the DCI may be released as allowed by law.

Signature	Date
Address	City, State, ZIP

WAIVER:

Iowa law does ***not*** require waiver. However, without a waiver any arrest over 18 months old ***without*** a disposition, cannot be given to a non-law enforcement agency.

Deferred judgments where DCI has received notice of successful completion of probation also cannot be given out to non-law enforcement agencies without a signed waiver.

General Information:

The information requested is based on ***name*** and ***exact date of birth only***. Without fingerprints a ***positive*** identification cannot be assured. If a person disputes the accuracy of information maintained by the Department, they may challenge the information by writing to the address on the front of this form or personally appearing at DCI headquarters during normal working hours.

The records maintained by the Iowa Department of Public Safety are based upon reports from other criminal justice agencies and therefore, the Department cannot guarantee the completeness of the information provided.

The criminal history check is of the Iowa Central Repository only. No other state or federal agency records can be searched under current law.

In Iowa, a deferred judgment is not considered a conviction once the defendant has been discharged after successfully completing probation. However, it should be noted that a deferred judgment may still be considered as an offense when considering charges for certain specified multiple offense crimes, i.e., second offense OWI. If a disposition reflects that a deferred judgment was given, you may want to inquire of the individual his or her current status.

Any questions in reference to Iowa criminal history records can be answered by writing to the address on the front of this form or calling (515) 725-6066 between 8:00 a.m. and 4:30 p.m., Monday through Friday.

If the “No CCH record found” box is checked, it could also mean that information in the file is not releasable per Iowa law without a waiver.

Reminder:

Each agency, other than day care, should submit a self-addressed envelope with their requests. This will expedite the process.

**FORM B IS FOR THE SPECIFIC PURPOSE SET OUT ON THE FRONT.
COURT ORDERED HOME STUDY MUST SUBMIT FORM A WITH PAYMENT.**