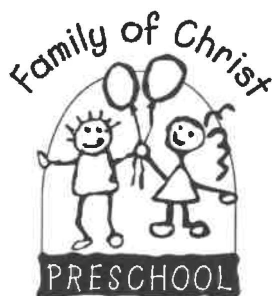


2020-2021 ENROLLMENT FORM

Name of Child______________________________ Birth Date _____ / _____ / ______

Nickname (name your child would like to be called at preschool)________________________

Address____________________________________ City__________________ Zip ____________

Email_______________________________________ (best email to reach parents)

Mother's Name_____________________________ Phone __________________________

Address ____________________________________ City_________________ Zip _____________

During the day Mother can be reached____

Employer___________________________________ Phone____________________________

Father's Name______________________________ Phone____________________________

During the day Father can be reached____

Employer___________________________________ Phone____________________________

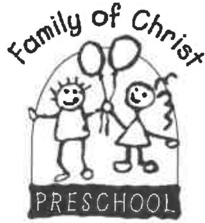
Permission to share phone number and address with other classmates ONLY Y N

Permission to use child's photo in brochures, flyers, video, website, etc. Y N

Does your child have any special needs: (i.e. food allergies, medical or special placement considerations?)

____

Parent Signature____ Date______________



2020-2021 EMERGENCY CARD

Name of Child_______________________________ Birth Date _____ / _____ / _____

Address_____________________________ City________________ Zip __________

Mother's Name__________________________ Home # ____________________

Work #________________________ Cell #______________________

Father's Name__________________________ Home # ____________________

Work #________________________Cell #______________________

EMERGENCY ALTERNATIVES: Adults who are authorized to pickup child from preschool other than parents

Name__________________________________ Phone #______________

Address_____________________________ City_____________ Zip __________

Name__________________________________ Phone #______________

Address _____________________________ City_____________ Zip__________

Physician________________ Address____________________ Phone___________

Hospital Preference __________________________________ Phone___________

Dentist_________________ Address____________________ Phone___________

Significant Medical Info____

Person **NOT AUTHORIZED** to pickup child from preschool___________________________

Ok to administer bug spray if needed Y N **Ok to administer sunscreen if needed Y N**

I give my permission to Family of Christ Lutheran Preschool staff to make whatever emergency (e.g. first aide, evacuation) measures are judged necessary for the care and protection of my child while under the supervision of the Preschool. In case of medical emergency, I understand that my child will be transported to the appropriate medical facility/local emergency unit for treatment, if the local emergency resource (police, rescue squad) deems it necessary. The child will be transported at the expense of ____

(Parent or parent insurance company and policy number.)

Parent Signature______________________________________ Date___________

HEALTH CARE SUMMARY

MUST BE COMPLETED BY HEALTH CARE SOURCE

Date of Enrollment: ____________________

NAME OF CHILD ______________________________ Birth Date ______________

ADDRESS ______________________________ Telephone ______________

PARENT(S) OR GUARDIAN ______________________________

Date of last physical examination __________ How long have you been seeing this child? ______________

How frequently do you see this child when he/she is not ill? ______________________________

Does this child have any allergies (including allergies to medications)? ______________________________

Is a modified diet necessary? ______________________________

Is any condition present that might result in an emergency? ______________________________

____

What is the status of the child's. . .

Vision ______________________________

Hearing ______________________________

Speech ______________________________

Please list below the important health problems

Important Health Problems	Followed By You	Followed By Other Med Source (Name)	Requires Special Attention at Center

Other information helpful to the child care program ______________________________

____

____

Phone ______________

Signature of Health Source ______________ Address ______________

Date ______________ ______________

MS-2083

Enter the dates for each vaccine your child has received to date. Specify the month, day, and year of each dose such as 01/01/2010.

Immunization Form

Name________________________ Birthdate__________

Immunizations required for child care, early childhood programs, and school.

Vaccine	Birth to 6 months			12 -24 months		At Kindergarten	At 7th grade	At 12th grade
Hepatitis B								
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)								
Haemophilus influenzae type b (Hib)								
Pneumococcal (PCV)								
Polio								
Measles, Mumps, Rubella (MMR)								
Chickenpox (varicella)								
Hepatitis A								
Tetanus, Diphtheria, Pertussis (Tdap)								
Meningococcal (MCV4)								

Minnesota law requires children enrolled in child care, early childhood education, or school to be immunized against certain diseases, unless the child is medically or non-medically exempt.

Instructions for parent or guardian:

1. Fill out the dates in chronological order even if your child received a vaccine outside of the age/grade category that the box is in. Depending on the age of your child, they may not have received all vaccines; some boxes will be blank.
   - If you have a copy of your child's immunization history, you can attach a copy of it instead of completing the front of this form.
   - Your doctor or clinic can provide a copy of your child's immunization history. If you are missing or need information about your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-3980 or 800-657-3970.
2. Sign or get the signatures needed for the back of this form.
   - Document medical and/or non-medical exemptions in section 1.
   - Verify history of chickenpox (varicella) disease in section 2.
   - Provide consent to share immunization information (optional) in section 3.

DEPARTMENT OF HEALTH
Immunization Program (2019)
www.health.state.mn.us/immunize

Instructions: Complete section 1 to document a medical or non-medical exemption, section 2 to verify history of varicella disease, and section 3 to consent to share immunization information.

Name ______________________

1. Document a medical and/or non-medical exemption (A and/or B).
Place an X in the box to indicate a medical or non-medical exemption. If there are exemptions to more than one vaccine, mark each vaccine with an X.

Vaccine	Medical Exemption	Non-Medical Exemption
Diphtheria, Tetanus, and Pertussis		
Polio		
Measles, Mumps, Rubella		
Haemophilus influenzae type b		
Chickenpox (varicella)		
Pneumococcal		
Hepatitis A		
Hepatitis B		
Meningococcal		

A. Medical exemption: By my signature below, I confirm that this child should not receive the vaccines marked with an X in the table for medical reasons (contraindications) or because there is laboratory confirmation that they are already immune.

Signature: ______________________ Date: __________
(of health care practitioner*)

B. Non-medical exemption: A child is not required to have an immunization that is against their parent or guardian's beliefs. However, choosing not to vaccinate may put the health or life of your child or others they come in contact with at risk. Unvaccinated children who are exposed to a vaccine-preventable disease may be required to stay home from child care, school, and other activities in order to protect them and others.

By my signature, I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs. I am aware that my child may be required to stay home from child care, school, and other activities if exposed.

Signature: ______________________ Date: __________
(of parent or guardian in presence of notary)

Non-medical exemptions must also be signed and stamped by a notary:

This document was acknowledged before me

on __________ (date)

by ______________________
(name of parent or guardian)

Notary Signature:

____

Notary Stamp

STATE OF MINNESOTA, COUNTY OF

____

2. History of chickenpox (varicella) disease. This child had chickenpox in the month and year __________

My signature below means that I confirm that this child does not need chickenpox vaccine because:

☐ I am a health care practitioner and this child was previously diagnosed with chickenpox or the parent provided a description that indicates this child had chickenpox in the past.

☐ I am the parent or guardian and this child had chickenpox on or before September 1, 2010.

Signature: ______________________ Date: __________
(of health care practitioner*, representative of a public clinic, or parent/guardian). Parent can sign if chickenpox occurred before September 2010.

*Health care practitioner is defined as a licensed physician, nurse practitioner, or physician assistant.

3. Consent to share immunization information: This school is asking for permission to share your child's immunization record with Minnesota's immunization information system. Giving your permission will:

- Provide easier access for you and your school to check immunization records, such as at school entry each year.
- Support your school in helping to protect students by knowing who may be vulnerable to disease based on their immunization record. This can be important during a disease outbreak.

Under Minnesota law, all the information you provide is private and can only be released to those authorized to receive it. Signing this section of the form is optional. If you choose not to sign, it will not affect the health or educational services your child receives.

I agree to allow my child's school to share my child's immunization documentation with Minnesota's immunization information system:

Signature: ______________________ Date: __________
(of parent/guardian)