FAX # 952-891-3469

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

Immunization Form

Name_____ Birthdate_____

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.

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)

Skills Evaluation

This is merely a tool to help us plan for your child's needs. Be assured that your child is "ready" for preschool, even if he/she doesn't know any of these skills yet.

Name_____ Birth Date_____ Assessment Date_____

Recognizes numbers circled

3 8 6 2 1

4 5 9 7 10

11 14 12 15 18

13 16 17 20 19

Can count by self from 1 to_____.

Please check those that apply:

_____ Knows full name (first, middle, last)

_____ Recognizes first name in print

_____Can say or sing alphabet?

_____ Can hold writing tool with effective grip

Recognizes colors circled

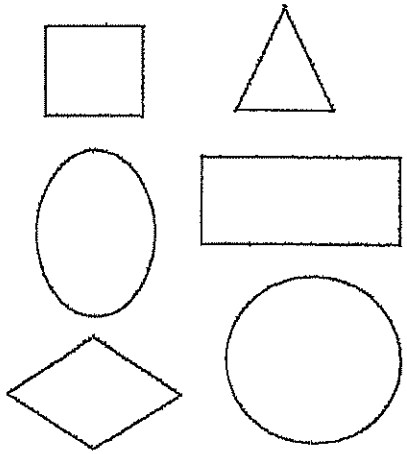
Red Blue Yellow

Green Purple Orange

Black Pink Brown

Grey White

Recognizes shapes circled



Recognizes letters circled

Aa Bb Ee Gg Jj Ff

Dd Cc Hh Ll Mm Pp

Ii Kk Oo Ss Nn Qq

Rr Tt Ww Zz Uu

Xx Vv Yy

Which hand does your child typically use for writing?
Right____ Left_____ Both _____

If your child can already print some letters, show us below!

Rev. 5/2020

Child's Name

To help us know you and your child better, please complete the information below.

Important people in my child's life:_____

_____

Pets and their names:_____

What special interests does your child have? (Favorite toys, activities, places to go, etc.)

_____

Religious Affiliation and Church Home, if any:_____
Was your child baptized? ____ yes, ____ no
What community or church classes has your child attended, if any?_____

Please provide a brief description of your child's characteristic personality:_____

_____

_____

Please describe any difficult or unusual behavior challenges:

_____

Please describe child's type of home discipline:_____

_____

Was your child born prematurely? _____
Does your child have any developmental delays of which you are aware?_____
Please list any concerns you have about your child's development:_____

_____

Have you completed the FREE preschool screening through your local school district (which must be conducted before entering a public school Kindergarten?) ____ yes ____ no

How do you hope Good Shepherd's Preschool will benefit your child?

_____

_____

_____

_____

Anything else you'd like to share that will help us prepare for your child's needs and/or get to know you better?

_____

_____

_____

_____

GOOD SHEPHERD PRESCHOOL EMERGENCY CONTACT / AUTHORIZED RELEASE FORM

Child's name_____ Date of Birth_____ Home Phone_____
Mother's name_____ Work Phone_____ Cell Phone_____
Address_____ City_____ Zip_____
Father's name _____ Work Phone_____ Cell Phone_____
Address _____ City _____ Zip _____

Emergency Contacts - The following persons may be contacted in the event of an emergency if the parent/guardian is unreachable. A minimum of two contacts must be provided.

Name_____ Phone _____ Cell Phone _____
Address _____ City _____ Zip _____
Name_____ Phone _____ Cell Phone _____
Address _____ City _____ Zip _____

Authorized Release - The following persons are authorized to pick up the above child from preschool. Good Shepherd requires photo ID prior to releasing the child.

Name_____ Phone _____ Cell Phone _____
Address _____ City _____ Zip _____
Name_____ Phone _____ Cell Phone _____
Address _____ City _____ Zip _____

In the case of a serious accident or medical condition, when I cannot be reached, I hereby authorize Good Shepherd Preschool to implement emergency procedures for the health and safety of my child. I understand that 911 will be called if deemed medically necessary. In the event that additional medical care is needed, I authorize medical personnel to transport my child to the following hospital:

_____

My child's primary physician is _____ and the clinic phone number is _____.
My child's dentist is _____ and the clinic phone number is _____.
Important information to be provided to the medical personnel includes _____
_____.

Health Insurance Provider _____ Policy Number _____

Parent Signature _____ Date _____

AUTHORIZATION FORM

School/Organization Name: Good Shepherd Lutheran School

FOR OFFICE USE ONLY	STUDENT #:	DATE:

Effective date of authorization: _____ Name of student: _____

Type of Authorization Form:
- ☐ New Authorization
- ☐ Change payment amount
- ☐ Change payment date
- ☐ Change banking information
- ☐ Discontinue electronic payment

Last Name	First Name	
Address		
City	State	Zip
Email		

TUITION PAYMENT PLAN (please check one):

☐ 12 Month Plan (Sept. through Aug.) ☐ 9 Month Plan (Sept. through May) ☐ Starting: _____, Ending: _____

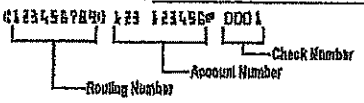
Date of first payment: ___/___/___ Date of last payment (optional): ___/___/___	Payment frequency: ☐ Monthly on 5th	Amount of first payment: $ _____ Amount of ongoing payment: $ _____ Amount of last payment (optional): $ _____

CHECKING / SAVINGS

Please debit payment from my (check one):
- ☐ Savings Account (contact your financial institution for Routing #)
- ☐ Checking Account (staple a voided check below)

Routing Number: _____
Valid Routing # must start with 0, 1, 2, or 3

Account Number: _____



I authorize the above organization to process debit entries to my account. I understand that this authority will remain in effect until I provide reasonable notification to terminate the authorization.

Authorized Signature: _____ Date: _____

If using a checking account, please attach a voided check at the bottom of this page.