

Family Child Care Admission and Arrangements

PLEASE PRINT. Complete one form for each child in care. This form must be kept on file at the family child care home. Please Note: Pursuant to MN Rules. 9502.0405, subpart 4, the provider shall obtain the required information for each child prior to admission.

The licensed child care provider completes items 1, 8, & 9 prior to the parent/guardian completing the rest of the form. Both parties sign the form when completed. The information requested will be maintained in a private manner and will not be released to anyone other than the licensing consultant without your prior written approval.

| | | | |
|--|------------------------|---|-------------------------------|
| 1. NAME OF CHILD CARE PROVIDER(S) (LAST, FIRST, MIDDLE) | | 2. CHILD'S NAME (LAST, FIRST, MIDDLE) | |
| ADDRESS | | CHILD'S DATE OF BIRTH | CHILD'S AGE |
| NAME OF SUPERVISING AGENCY | | TELEPHONE | 3. DATE ENROLLED IN CARE |
| 4. PARENT INFORMATION | PARENT/GUARDIAN | | PARENT/GUARDIAN |
| NAME | | | |
| PLACE OF EMPLOYMENT | | | |
| ADDRESS OF EMPLOYMENT | | | |
| WORK TELEPHONE | | | |
| HOME ADDRESS | | | |
| CONTACT NUMBERS | HOME PHONE | CELL PHONE | HOME PHONE |
| | | | CELL PHONE |
| 5. RESPONSIBLE FRIEND/RELATIVE TO CALL IF PARENTS CANNOT BE REACHED | | 6. NAMES OF ALL PERSONS AUTHORIZED TO REMOVE THE CHILD FROM THE HOME | |
| NAME | | | |
| ADDRESS | | | |
| TELEPHONE | RELATIONSHIP | | |
| 7. EMERGENCY CONTACT INFORMATION FOR CHILD | | HOSPITAL TO BE USED FOR EMERGENCIES | |
| PHYSICIAN'S NAME | | ADDRESS | |
| TELEPHONE | | CITY, STATE, ZIP CODE | |
| NAME OF PARENT'S MEDICAL INSURANCE COMPANY | | CONTRACT # | |
| IF UNAVAILABLE, ANOTHER LICENSED PHYSICIAN MAY TREAT MY CHILD | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| DENTIST'S NAME | | ADDRESS | |
| TELEPHONE | | CITY, STATE, ZIP CODE | |
| NAME OF PARENT'S DENTAL INSURANCE COMPANY | | CONTRACT # | |
| IF UNAVAILABLE, ANOTHER LICENSED DENTIST MAY TREAT MY CHILD | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 8. ARRANGEMENTS | FINANCIAL ARRANGEMENTS | | |
| SERVICES PROVIDED (INCLUDING DAYS, HOURS, MEALS ETC.) | | | |
| SPECIAL CONDITIONS (SPECIAL DIET, SPECIAL NEEDS, ALLERGIES) | | | |
| 9. LIABILITY INSURANCE NOTIFICATION: | | | |
| Pursuant to 245A.152 (a) A license holder must provide a written notice to all parents or guardians of all children to be accepted for care prior to admission stating whether the license holder has liability insurance. This notice may be incorporated into and provided on the admission form used by the license holder. Check one below | | | |
| <input type="checkbox"/> I <u>do</u> have liability insurance. A current certificate of coverage of insurance is available for inspection to all parents/guardians of children receiving services and to all parents seeking services from the family child care program. My policy will expire on (month/day/year) _____. | | | |
| <input type="checkbox"/> I <u>do not</u> have liability insurance. | | | |
| 10. PERMISSIONS | | AUTHORIZATION IS HEREBY GIVEN TO THE CHILD CARE PROVIDER AS NAMED IN ITEM 1 ABOVE, TO OBTAIN EMERGENCY MEDICAL CARE OR TREATMENT IN THE EVENT OF AN EMERGENCY | |
| | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | AUTHORIZATION IS HEREBY GIVEN TO THE CHILD CARE PROVIDER AS NAMED IN ITEM 1 ABOVE, TO PROVIDE TRANSPORTATION TO MY CHILD | |
| | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| AUTHORIZATION: We the undersigned hereby agree to abide by the arrangements and authorizations so stated above. We have discussed the information required in the rule part 9502.0405. | | | |
| SIGNATURE OF CHILD CARE PROVIDER | | DATE | SIGNATURE OF PARENT/ GUARDIAN |
| | | | DATE |

Student Immunization Form

Student Name _____

Birthdate _____ Student Number _____

Minnesota law requires children enrolled in school to be immunized against certain diseases or file a legal medical or conscientious exemption.

FOR SCHOOL USE ONLY

- () Complete; booster required in _____
 () In process; 8 mos. expires _____
 () Medical exemption for _____
 () Conscientious objection for _____
 () Parental/guardian consent _____

Parent/Guardian:

You may attach a copy of the child's immunization history to this form OR enter the MONTH, DAY, and YEAR for all vaccines your child received. Enter MED to indicate vaccines that are medically contraindicated including a history of disease, or laboratory evidence of immunity and CO for vaccines that are contrary to parent or guardian's conscientiously held beliefs.

Sign or obtain appropriate signatures on reverse. Complete section 1A or 1B to certify immunization status and section 2A to document medical exemptions (including a history of varicella disease) and 2B to document a conscientious exemption.

Additionally, if a parent or guardian would like to give permission to the school to share their child's immunization record with Minnesota's immunization information system, they may sign section 3 (optional).

For updated copies of your child's vaccination history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-5503 or 800-657-3970.

School Personnel: Be sure to initial and date any new information that you add to this form after the parent/guardian submits it. Also, record combination vaccines (e.g., DTaP+HepB+IPV, Hib+HepB) in each applicable space.

| Type of Vaccine | DO NOT USE (✓) or (✗) | 1st Dose Mo/Day/Yr | 2nd Dose Mo/Day/Yr | 3rd Dose Mo/Day/Yr | 4th Dose Mo/Day/Yr | 5th Dose Mo/Day/Yr |
|---|-----------------------|-----------------------|-----------------------|-----------------------|--|-----------------------|
| Required (The shaded boxes indicate doses that are not routinely given; however, if your child has received them, please write the date in the shaded box.) | | | | | | |
| Diphtheria, Tetanus, and Pertussis (DTaP, DTP, DT) • for children age 6 years and younger • final dose on or after age 4 years | | | | | | |
| Tetanus and Diphtheria (Td) • for children age 7 years and older • 3 doses of Td required for children not up to date with DTaP, DTP, or DT series above | | | | | 5th dose not required if 4th dose was given on or after the 4th birthday | |
| Tetanus, Diphtheria and Pertussis (Tdap) • for children in 7th - 12th grade | | | | | | |
| Polio (IPV, OPV) • final dose on or after age 4 years | | | | | | |
| Measles, Mumps, and Rubella (MMR) • minimum age: on or after 1st birthday | | | | | | |
| Hepatitis B (hep B) | | | | | | |
| Varicella (chickenpox) • minimum age: on or after 1st birthday • vaccine or disease history required | | | | | | |
| Meningococcal (MCV, MPSV) • for children in 7th - 12th grade • booster given at age 16 years | | | | | | |
| Recommended | | | | | | |
| Human Papillomavirus (HPV) | | | | | | |
| Hepatitis A (hep A) | | | | | | |
| Influenza (annually for children 6 months and older) | | | | | | |

Additional exemptions:

- Children 7 years of age and older:** A history of 3 doses of DTaP/DTP/DT/Td/Tdap and 3 doses of polio vaccine meets the minimum requirements of the law.
- Students in grades 7-12:** A Tdap at age 11 years or later is required for students in grades 7-12. If a child received Tdap at age 7-10 years another dose is not needed at age 11-12 years. However, if it was only a Td, a Tdap dose at age 11-12 years is required.
- Students 11-15 years of age:** A 3rd dose of hepatitis B vaccine is not required for students who provide documentation of the alternative 2-dose schedule.
- Students 18 years of age or older:** Do not need polio vaccine.

Instructions, please complete:

Box 1 to certify the child's immunization status

Box 2 to file an exemption (medical or conscientious)

Box 3 to provide consent to share immunization information (optional)

1. Certify Immunization Status. Complete A or B to indicate child's immunization status.

A. Received all required immunizations:

I certify that this student has received all immunizations required by law.

Signature of Parent / Guardian OR Physician / Public Clinic

Date

B. Will complete required immunizations within the next 8 months:

I certify that this student has received at least one dose of vaccine for diphtheria, tetanus, and pertussis (if age-appropriate), polio, hepatitis B, varicella, measles, mumps, and rubella and will complete his/her diphtheria, tetanus, pertussis, hepatitis B, and/or polio vaccine series within the next 8 months.

The dates on which the remaining doses are to be given are:

Signature of Physician / Public Clinic

Date

2. Exemptions to School Immunization Law. Complete A and/or B to indicate type of exemption.

A. Medical exemption:

No student is required to receive an immunization if they have a medical contraindication, history of disease, or laboratory evidence of immunity. For a student to receive a medical exemption, a physician, nurse practitioner, or physician assistant must sign this statement:

I certify the immunization(s) listed below are contraindicated for medical reasons, laboratory evidence of immunity, or that adequate immunity exists due to a history of disease that was laboratory confirmed (for varicella disease see * below). List exempted immunization(s):

Signature of physician/nurse practitioner/physician assistant

Date

*History of varicella disease only. In the case of varicella disease, it was medically diagnosed or adequately described to me by the parent to indicate past varicella infection in _____ (year)

Signature of physician/nurse practitioner/physician assistant (If disease occurred before September 2010, a parent can sign.)

B. Conscientious exemption:

No student is required to have an immunization that is contrary to the conscientiously held beliefs of his/her parent or guardian. However, not following vaccine recommendations may endanger the health or life of the student or others they come in contact with. In a disease outbreak schools may exclude children who are not vaccinated in order to protect them and others. To receive an exemption to vaccination, a parent or legal guardian must complete and sign the following statement and have it notarized:

I certify by notarization that it is contrary to my conscientiously held beliefs for my child to receive the following vaccine(s):

Signature of parent or legal guardian

Date

Subscribed and sworn to before me this: _____
day of _____ 20____

Signature of notary

3. Parental/Guardian Consent to Share Immunization Information (optional):

Your child's school is asking your permission to share your child's immunization documentation with MIIC, Minnesota's immunization information system, to help better protect students from disease and allow easier access for you to retrieve your child's immunization record. You are not required to sign this consent; it is voluntary. In addition, all the information you provide is legally classified as private data and can only be released to those legally authorized to receive it under Minnesota law.

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

Signature of parent or legal guardian

Date



Birch Grove Community School Internet Access Form

Dear Birch Grove parents/guardians:

Birch Grove Community School students use computers and the internet as a part of our educational program. The use in the computer lab is monitored by school staff. We do have a content filtering service to deny access to inappropriate or offensive internet sites. It is, however, virtually impossible to deny access to all sites that parents may feel are inappropriate. If your child experiences access to any sites deemed inappropriate, please let the school know immediately. The site will be reviewed and appropriate action taken.

Email accounts will not be set up for the students.

Please check the appropriate box below, and sign and date this form.

☐ Yes, allow my child access to the internet

☐ No, my child is not allowed to access the internet

Student name

Parent/guardian's signature

Date



Birch Grove Community School
Post Office Box 2383
Tofte, MN 55615
(218) 663-0170 – Fax (218) 663-7904

UNIVERSAL OFF CAMPUS PERMISSION FORM

I hereby grant permission for my child, _____
to participate in classroom walking field trips, and special classroom activities
that may include leaving the school campus. Unless I send a note specifically
to exclude my child from any of the above activities, my child will be allowed
to accompany his/her class.

Parent/Guardian Signature



PHOTO RELEASE FOR MINORS

I, being the Parent/Guardian of _____, hereby consent that the photographs of Birch Grove Community School activities in which she/he appears may be used by Birch Grove Community School, its assigns or successors, in whatever way Birch Grove Community School may desire, including but not limited to, audiovisual productions, television, website production, brochures, other media, and other uses as Birch Grove Community School deems appropriate.

Birch Grove Community School shall not be obligated to provide me with any prior notice of the use of these photographs or films. Furthermore, I hereby consent that such photographs and the plates or films from which they are made shall be the property of Birch Grove Community School and that Birch Grove Community School shall have the right to duplicate or reproduce such photographs and plates as it may desire, free and clear of any claims whatsoever on my part.

As the Parent/Guardian of _____, I have the authority to sign on behalf of my child in this matter.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Signature of Parent/Guardian