

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 \_\_\_\_\_

fold

\_\_\_\_\_  
Date \_\_\_\_\_ Parent Signature

\_\_\_\_\_  
Policy number \_\_\_\_\_ Health Insurance Provider

\_\_\_\_\_  
Important information to be provided to the medical personnel includes

\_\_\_\_\_  
My child's dentist is \_\_\_\_\_ and the clinic phone number is \_\_\_\_\_

\_\_\_\_\_  
My child's primary physician is \_\_\_\_\_ and the clinic phone number is \_\_\_\_\_

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 emergency medical care is needed, I authorize medical personnel to transport my child to the following hospital:

OR Ask Clinic to Fax Records to us at:  
952-891-3469

## Child Care Immunization Form

Must be on file **before** a child attends child care

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Date of Enrollment \_\_\_\_\_

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

### 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.

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.

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
<b>Required</b> (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.)						
<b>Diphtheria, Tetanus, and Pertussis (DTaP, DTP)</b> <ul style="list-style-type: none"> <li>• 3 doses during 1st year (at 2-month intervals)</li> <li>• 4<sup>th</sup> dose at 12-18 months</li> <li>• 5<sup>th</sup> dose at 4-6 years</li> </ul> Indicate vaccine type: DTaP or DTP						5th dose not required if 4th dose was given on or after the 4th birthday
<b>Polio (IPV, OPV)</b> <ul style="list-style-type: none"> <li>• 2 doses in the first year</li> <li>• 3<sup>rd</sup> dose by 18 months</li> <li>• 4<sup>th</sup> dose at 4-6 years</li> </ul>						4th dose not required if 3rd dose was given on or after the 4th birthday
<b>Measles, Mumps, and Rubella (MMR)</b> <ul style="list-style-type: none"> <li>• Required for children 15 months and older</li> <li>• 1<sup>st</sup> dose on or after 1<sup>st</sup> birthday</li> <li>• 2<sup>nd</sup> dose at 4-6 years</li> </ul>						
<b>Haemophilus influenzae type b (Hib)</b> <ul style="list-style-type: none"> <li>• 2-3 doses in the first year</li> <li>• 1 dose required after 12 months or older</li> <li>• For unvaccinated children 15-59 months, 1 dose is required</li> <li>• Not required for children 5 years or older</li> </ul>						
<b>Varicella (chickenpox)</b> <ul style="list-style-type: none"> <li>• Required for children 15 months and older</li> <li>• 1<sup>st</sup> dose on or after 1<sup>st</sup> birthday</li> <li>• 2<sup>nd</sup> dose at 4-6 years</li> </ul>						
<b>Pneumococcal Conjugate Vaccine (PCV)</b> <ul style="list-style-type: none"> <li>• 3 doses in the first year</li> <li>• 4<sup>th</sup> dose after 12 months</li> <li>• At least 1 dose is recommended for children 24-59 months in child care</li> </ul>						
<b>Hepatitis B (hep B)</b> <ul style="list-style-type: none"> <li>• 2-3 doses in the first year</li> <li>• 3<sup>rd</sup> dose (final dose) as late as 18 months</li> </ul>						
<b>Hepatitis A (hep A)</b> <ul style="list-style-type: none"> <li>• 2 doses separated by 6 months for children 12 months and older</li> </ul>						
<b>Recommended</b>						
<b>Rotavirus</b> (2-3 doses between 2 and 6 months)						
<b>Influenza</b> (annually for children 6 months or older)						

Name \_\_\_\_\_

**Instructions, please complete:**

Box 1 to certify the child's immunization status

Box 2 to file an exemption (medical or conscientious)

<b>1. Certify Immunization Status.</b> Complete A or B to indicate child's immunization status.	
<b>A. Children who are 15 months or older:</b> For children who are 15 months or older and who have received all the immunizations required by law for child care:  I certify that that the above-named child is at least 15 months of age and has completed the immunizations which are required by law for child care.  _____ Signature of Parent / Guardian OR Physician / Nurse Practitioner / Physician Assistant / Public Clinic  _____ Date	<b>B. Children who are 15 months or younger:</b> For children who are younger than 15 months OR have not received all required immunizations:  I certify that the above-named child has received the immunizations indicated. In order to remain enrolled this child must receive all required vaccines within 18 months from initial enrollment date. The dates on which the remaining doses are to be given are:  _____ Signature of Physician / Nurse Practitioner / Physician Assistant / Public Clinic  _____ Date

<b>2. Exemptions to Immunization Law.</b> Complete A and/or B to indicate type of exemption.	
<b>A. Medical exemption:</b> No child is required to receive an immunization if they have a medical contraindication, history of disease, or laboratory evidence of immunity. For a child 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>B. Conscientious exemption:</b> No child 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 child or others they come in contact with. In a disease outbreak, children who are not vaccinated may be excluded 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

## Health Information Form

Child's Name \_\_\_\_\_ Birth date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

Zip \_\_\_\_\_ Phone Number \_\_\_\_\_

Date of last physical examination \_\_\_\_\_

Are all immunizations current for this child? \_\_\_\_\_

Any current medications? Please list. \_\_\_\_\_

\_\_\_\_\_

Does this child have any severe allergies? Please explain. \_\_\_\_\_

\_\_\_\_\_

Is a modified diet necessary? If so, please explain \_\_\_\_\_

\_\_\_\_\_

Important information regarding the child's vision, hearing or speech? \_\_\_\_\_

\_\_\_\_\_

Is any condition present that might result in an emergency? \_\_\_\_\_

\_\_\_\_\_

Please list any significant health problems or concerns or helpful information. \_\_\_\_\_

\_\_\_\_\_

Child's primary physician \_\_\_\_\_ Phone \_\_\_\_\_

Child's dentist \_\_\_\_\_ Phone \_\_\_\_\_

Health insurance provider \_\_\_\_\_ Policy # \_\_\_\_\_

In the event of an emergency, I authorize Good Shepherd Preschool to implement emergency medical procedures as needed for the health and safety of my child.

Parent signature \_\_\_\_\_ Date \_\_\_\_\_

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

<u>Important Health Problems</u>	<u>Followed By You</u>	<u>Followed By Other Med Source (Name)</u>	<u>Requires Special Attention at Center</u>
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\_\_\_\_\_  
\_\_\_\_\_

Other information helpful to the child care program \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Phone \_\_\_\_\_

**Signature of Health Source** \_\_\_\_\_

Address \_\_\_\_\_

**Date** \_\_\_\_\_

Name \_\_\_\_\_

### SKILLS EVALUATION

Birth Date \_\_\_\_\_

*This is merely a tool to help me 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.*

Assessment Date \_\_\_\_\_

#### Recognizes numbers circled

3	8	6	2
1	4	5	9
	10	7	

#### Recognizes colors circled

Red      Blue      Yellow

Green      Purple      Orange

Black      Pink      Brown

#### Recognizes letters circled

A      B      E      G      J      C

F      D      H      L      M      P

I      K      O      S      N      Q

R      T      W      Z      U      X

V      Y

Can count from 1 to \_\_\_\_\_ by self

Please check those that apply:

\_\_\_\_ Knows full name (first, middle, last)

\_\_\_\_ Recognizes first name in print

\_\_\_\_ Can say or sing alphabet?

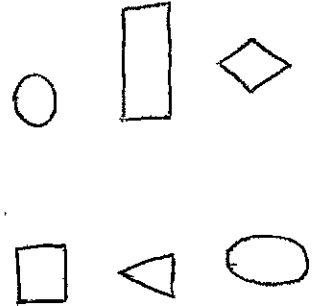
\_\_\_\_ Can hold writing tool correctly

\_\_\_\_ Has used a scissors

Which hand does your child typically use for writing?

Right \_\_\_\_\_ Left \_\_\_\_\_ Both \_\_\_\_\_

#### Recognizes shapes circled



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

\_\_\_\_\_ 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: \_\_\_\_\_

Is 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?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Supplies for Good Shepherd Preschool

### ***Please label all items below!***

Backpack

Sturdy Pocket Folder

4" x 6" Family Photo - For display at school

Spiral Notebook - *Mrs. Streckert's Class only*

Small/Medium sized easy-to-use water bottle - bring daily

Tennis Shoes - NO open-toed sandals or slippery "dress shoes"

Velcro closures are recommended and work great for groups of preschoolers!

Change of Clothing in ziplock plastic bag to be kept in backpack for accidents

(Include underwear, pants, shirt and socks)

Winter Outdoor Clothing: Snowpants, boots, mittens, hat

### ***These items do NOT need to be labeled - they will be shared!***

Box of Dixie Cups (5 oz. only please)

Box of 24 Crayola Crayons

4 oz. Bottle of Elmer's Washable School Glue

Large Box of Kleenex Tissues

1/2" 3-ringed Binder - for storing Jesus Story Sheets in at home (and page protectors?)