

St. Paul Lutheran Preschool
621 Main St. W
Pipestone, MN 56164
507-825-2142

A \$30 nonrefundable registration fee is due with this form. Registration fee for the upcoming school year is due by May 1st to secure your child's spot. After May 1st, if unpaid the spot will be offered to a student on the waiting list. ____ Registration Fee Paid

Class Registering For: () 3/4 T/TH Morning () 4/5 MWF Morning Class () 4/5 T/TH Afternoon
() 4/5 5 Day Program M-F Afternoon
() 4/5 5 Day Program MWF Morning and T/TH Afternoon

Student Information

Last Name _____ First _____ Middle _____
Home Address _____ City _____ State _____ Zip _____
Home Phone _____ Birthday _____

Does the student have a current church home, if so, name of church: _____

Is the student baptized? () Yes () No Student lives with: () Both parents () Mother () Father

Has child completed Preschool Screening? () Yes () No

Any areas of weakness noted: _____

Any areas of strength noted: _____

Other information for us to know: _____

Parent/ Guardian Information

Father's Name _____ Employment: _____
Home/Cell Phone _____ Work Phone: _____ Email: _____
Text? () Y () N _____ Home Church: _____ Baptized? () Yes () No

Mother's Name _____ Employment: _____
Home/Cell Phone _____ Work Phone: _____ Email: _____
Text? () Y () N _____ Home Church: _____ Baptized? () Yes () No

If applicable, Guardian(s) name: _____

Address: _____

Name and ages of other children in household: _____

Medical and Emergency Information

Medical Concern or Allergies: _____

Physician _____ Phone _____ Address _____

Dentist _____ Phone _____ Address _____

Emergency Contact (Not a parent or guardian)

Name _____ Phone _____ Address _____

Name _____ Phone _____ Address _____

People other than parents/guardian authorized to pick up your child:

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

If applicable, anyone not authorized to pick up your child but may attempt to do so: _____

If child attends a daycare:

Name _____ Phone _____ Address _____

() I authorize the Pipestone Transit Service to pick up my child to (address): _____

() Regular Basis () Occasional

St. Paul Preschool must be contacted each time your child is making a change in their regular riding schedule or when riding on an occasional basis.

Parental Consent

1. I authorize any staff from St. Paul Lutheran to transport my child to receive emergency medical attention.
2. I understand that I may review the Child Care Program upon request to the school.
3. I understand that I must notify the school at the onset of contagious disease within 24 hours.
4. I understand that the school does not administer medication, except Syrup of Ipecac when necessary.
5. I understand the policies and procedures of St. Paul Preschool in case of emergency or injury.
6. I understand the school's policies and procedures for administering First Aid and other medical care.
7. I give permission for the school to act in an emergency or when parent and other contacts above cannot be reached or is delayed.

I give my consent to the above policies: Signature _____ Date: _____

The completion of this application form and signature constitutes an agreement that any tuition or fees pertaining to this student's enrollment at St. Paul Preschool will be paid as agreed. This includes the \$30 nonrefundable registration fee as well as tuition as agreed and publicized for the year. Tuition is due monthly unless other arrangements are made with the Director. It is assumed that the child will be enrolled for the full school year unless exceptional circumstances arise.

Signature _____ Date _____

Photo Release

The staff at St. Paul Lutheran may take pictures of your children to be used during the school year. I authorize St. Paul Lutheran Church and Preschool staff to take pictures of my child(ren). I also give permission for display of pictures within the facility. This may occasionally include the use of video and/or live streaming through the social media pages. I give permission for such photo uses to be used on St. Paul social media and website pages.

Signature _____ Date _____

Child Emergency Contact Information

This form is a resource for your emergency preparedness. You should collect each child's emergency contact information and be prepared to take the contact information with you in instances of evacuation and/or relocation. This is information that a parent or guardian can provide you.

CHILD'S NAME	DATE OF BIRTH
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Parent/Guardian Contact Information

PARENT/GUARDIAN 1			
NAME		RELATIONSHIP TO CHILD	
ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	ALTERNATE PHONE NUMBER		
EMAIL	WORK EMAIL	WORK PHONE NUMBER	
PARENT/GUARDIAN 2			
NAME		RELATIONSHIP TO CHILD	
ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	ALTERNATE PHONE NUMBER		
EMAIL	WORK EMAIL	WORK PHONE NUMBER	

Emergency Contact Information (not a parent/guardian)

EMERGENCY CONTACT 1 (NOT A PARENT GUARDIAN)			
NAME		RELATIONSHIP TO CHILD	
ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	ALTERNATE PHONE NUMBER		
EMERGENCY CONTACT 2 (NOT A PARENT GUARDIAN)			
NAME		RELATIONSHIP TO CHILD	
ADDRESS	CITY	STATE	ZIP CODE

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 _____

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.

Birth to 6 months

12 -24 months

At Kindergarten

At 7th grade

At 12th grade

Vaccine

Hepatitis B	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Haemophilus influenzae type b (Hib)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pneumococcal (PCV)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Polio	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Measles, Mumps, Rubella (MMR)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Chickenpox (varicella)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hepatitis A	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Tetanus, Diphtheria, Pertussis (Tdap)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Meningococcal (MCV4)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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:

- 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.
- 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.

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		
<i>Haemophilus influenzae</i> 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*)

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.

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.

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: _____

STATE OF MINNESOTA, COUNTY OF _____

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)