Child's Name _____ Birthdate _____

Home Address _____
Street City Zip

Parents Name _____ Home Phone _____
First Last

Cell Phone _____ Work Phone _____

Parents Name _____ Home Phone _____
First Last

Cell Phone _____ Work Phone _____

Emergency Contact _____ Phone _____

Relationship to Student _____

Emergency Contact _____ Phone _____

Relationship to Student _____

Day Care Provider/HeadStart/Other _____ Phone _____

Allergy/Medical Information _____

_____

Doctor _____ Clinic _____ Phone _____

Insurance Company & Member # _____

I agree to release District 877 Community Education/ECFE and it's employees of all liability from accidents or injuries. I give permission to seek and/or transport my child in case of an emergency for medical treatment to the nearest medical facility.

Parent Signature _____ Date _____

During preschool, my son/daughter may be picked up by the following people:

	Name	Phone Number
Daycare	_____	_____
Car Pool	_____	_____
	_____	_____

_____ Parents Only -- unless written note accompanies child to class

Early Childhood Family Education
BHM SCHOOLS

Early Childhood Family Education
Discovery Center
301 2nd Ave NE, Buffalo, MN 55313
763.682.8780 | f:763.682.8795
bhmschools.org

Ready Set Grow Preschool -Spring Into Preschool Child Registration Information

MUST RETURN TO THE ECFE OFFICE, BY **JULY 30, 2021**

child last name: _____ child first name & (nickname): _____(_____)

Please circle the days of attendance: M T W TH F and the time of day: AM PM Teacher:_____

child health information and allergy information:_____

parent #1 name:_____phone:_____ mailing address:_____

email address:_____ work phone:_____

parent #2 name:_____phone:_____ mailing address:_____

email address:_____ work phone:_____

Name of individuals and contact information for those who may pick up your child from the preschool program.

_____ _____

Please indicate with a check mark, **ALL** of the statements **that apply to your child.** Leave blank any that do not apply.

- ❑ My child has a medical plan: Please share the plan with the teacher and District Nurse, Heidi Gallart at 763.682.8514.
- ❑ My child's immunization information has been updated and provided during early childhood screening or at preschool registration
- ❑ My child is transported to and from preschool by bus: Trailblazer or Vision (school district)
- ❑ My child is transported to and from preschool by family member or childcare provider
- ❑ My child may ONLY be picked up by a parent, unless a written note/email is provided to the contrary.
- ❑ My child attends daycare/childcare. provider name:_____phone number:_____
- ❑ My child may have his/her photo taken for inclusion in the digital classroom sharing platform.
- ❑ I give permission for the teacher to add parent #1 and parent #2 names and email addresses to the digital platform used by my child's class.
- ❑ parent #1 signature_____
- ❑ parent #2 signature_____

This will allow the classroom teacher to communicate with you through SEE SAW or CLASS TAG digital platforms throughout the program year.

Buffalo Hanover Montrose
BHM SCHOOLS

2021-22 ECFE HEALTH AND EMERGENCY FORM

Student Name _____

Student Information

Grade____ Gender ____ Birthdate _____ Teacher _____

Parent/Guardian (Primary residence/custodial parent) ☐ ☐ Check for unlisted phone number

Name _____ Relationship _____

Address _____ City/State/Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Other Phone _____

E-Mail #1 _____ E-Mail #2 _____

Parent/Guardian ☐ ☐ Check for unlisted phone number

Name _____ Relationship _____

Address _____ City/State/Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Other Phone _____

E-Mail #1 _____ E-Mail #2 _____

Emergency Contact (other than parent/guardian - parents will be notified first for illness/emergency)

First Contact _____ Second Contact _____

Relationship _____ Relationship _____

City _____ City _____

Phone _____ Phone _____

PLEASE NOTIFY THE SCHOOL IF ANY OF THE ABOVE INFORMATION CHANGES DURING THE SCHOOL YEAR

The following is a one time permission that will follow your child while enrolled in Buffalo-Hanover-Montrose Schools. Should you change your mind, please notify your child's school in writing.

I have received "Minnesota Department of Health Potassium Iodide (KI): What it is and what it does".

My Child MAY ☐ MAY NOT ☐

receive potassium iodide at the recommended dose as directed by the Minnesota Department of Health in the event of a Nuclear Incident at the Monticello Nuclear Power Plant.

My child has a known iodine allergy Yes ☐ No ☐

**Please note, students without completed permission forms WILL NOT be offered KI in the event of a nuclear incident.

Signature _____ Date _____
Parent/Guardian

PLEASE COMPLETE BOTH SIDES

➡

HEALTH INFORMATION

Student Name

Please note: It is the parent's responsibility to alert the bus company of any health concerns the student may have.

Privacy statement: In accordance with the Minnesota Government Data Privacy Act, the information you provide *may* be shared with district staff involved with your child based on an educational need. Any information shared with others cannot be done so without your permission. School personnel are mandated reporters for suspected child abuse/neglect as well as suspected excessive/habitual use of illegal drugs by a parent or guardian. You have the right to withhold health information however, in doing so the school may not be able to provide the safest environment for your child.

Does Your Child Have: Please check ALL that apply

☐ Asthma ☐ I have completed an asthma action plan for this school year.
☐ I need an asthma action plan for my student for this school year.
Inhalers ☐ Kept with teacher.
☐ Kept with student.
An Action Plan must be completed annually.

☐ Allergies
List _____
_____
Treatment _____
_____
Emergency Medications? Y ☐ N ☐
☐ Antihistamine (e.g. Benadryl, Zyrtec) ☐ Epinephrine Auto Injector (e.g. Epi Pen, AuviQ)
If a student uses emergency medications, an Allergy Action Plan must be completed annually.

☐ ADD/ADHD
Medications _____
Given: ☐ At Home ☐ At School

☐ Bleeding Disorders (ie: ITP, hemophilia)
Describe _____

☐ Cancer Type _____

☐ Diabetes
☐ Type I Treatment _____
☐ Type II Treatment _____
Please complete a Diabetes School Management and Emergency Plan annually.

☐ Headaches ☐ Migraine ☐ Non Migraine (greater than 4 a month)
☐ Medications as needed _____
_____
Family must supply student's medications

☐ Heart Condition
☐ Murmur with no limitations
☐ Other
Describe _____
Medications _____

☐ Mental Health
Describe _____
Medications _____

☐ Orthopedic Concerns
Type _____
☐ Limitations
Describe _____
☐ No Limitations

☐ Seizure
☐ Febrile only (suggest Tylenol/Ibuprofen in health office)-(no health plan necessary)
☐ Other Describe _____
Medications _____
Please complete a Seizure Health and Emergency Plan annually.

☐ Other (ie: activity restrictions, neurological, mobility, hearing, vision problems, special dietary needs)
Describe concern:
_____
_____
_____

Doctor _____ Clinic _____

Signature _____
Parent/Guardian

To consult with the school nurse please contact Heidi Gallart, RN at 763-682-8514 or at hgallart@bhmschools.org

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)