HEARTLAND CHRISTIAN ACADEMY PRESCHOOL STUDENT'S RECORDS

HEARTLAND CHRISTIAN ACADEMY

Child's Full Legal Name: _____
Last First Middle

Preferred Name:_____Gender_____Date of Birth_____

Address: _____

City _____ State _____ Zip Code _____

Mother/Legal Guardian:_____

Address IF different from child:_____

City _____ State _____ Zip Code _____

Preferred Phone # _____ Secondary Phone # _____

Email Address: _____

Father/Legal Guardian _____

Address IF different form child_____

City _____ State _____ Zip Code _____

Preferred Phone #_____ Secondary Phone # _____

Email Address: _____

Parent or Guardian How may we reach you doing school hours?

☐ By Phone Number to use:_____

☐ Other Explain: _____

Emergency Contacts in case of an injury requiring medical attention IF parent cannot be reached.

Please list two:

Name _____ Address _____

Phone Number _____ Relationship _____

☐ Authorized to take Child from school

Name _____ Address _____

Phone Number _____ Relationship _____

☐ Authorized to take Child from school

Additional Persons who are authorized to take Child from school:

Name: _____ Phone Number _____

Name: _____ Phone Number _____

HEARTLAND CHRISTIAN ACADEMY PRESCHOOL STUDENT'S RECORDS

HEARTLAND CHRISTIAN ACADEMY

Regular Medical Doctor (In Case of Emergency)

Name: _____ Clinic _____

Phone Number _____

Dentist: (In Case of Emergency) _____

Name: _____ Clinic _____

Phone Number _____

I, _____ authorize Heartland Christian Academy to act in an emergency,
Parent/Legal Guardian or when I cannot be reached, or I am delayed.

Signed _____

Print Name _____

Child's Height _____ Weight _____

Is there any other information that might be helpful for us to know about your child's health or circumstances at home that could affect him/her at school? ☐ YES ☐ NO If Yes, Please explain _____

_____

_____

Forms needed to be submitted prior to school
□ Health Care Summary ** Must be signed by Medical Provider
□ Immunization Records OR □ Signed AND Notarized statement of parental objection of immunizations/medical exemption Form

Days child will be attending school: □ Full time □ M-W-F □ T-TH □ Other_____
Will your child be in Before or After Care? □ YES □ No

Please check the following:
□ I have Supplied Sun Screen, which can be applied to my student by Heartland Staff.

□ I have been notified that I am required to include no less than ⅓ of the USDA Daily requirements in my child's lunch. They are as follows:

- 1 and ⅓ ounces of grain or ½ slice of bread (enriched or whole grain)
- ½ cup of vegetables and ½ cup of fruit or
- 1 cup vegetable and no fruit, or 1 cup fruit and no vegetable
- 1 and ½ ounce protein
- 7 ounces of milk

If these are not present in my child's lunch, I will be called and I agree to bring in what is missing to the school in time for lunch.

Parent Signature: _____ Date _____

PRESCHOOL HEALTH CARE SUMMARY

MUST BE COMPLETED BY HEALTH CARE SOURCE

Name of Child _____ Birth Date_____

Parent (Guardian) _____

Providers Name:_____ Health Care Facility _____

Does this child have any allergies (including allergies to medications)? ☐ YES ☐ NO _____

_____

Is a modified diet necessary? ☐ YES ☐ NO _____

Any condition present that might result in an emergency? ☐ YES ☐ NO _____

_____

What is the status of the childs: Vision _____

Hearing _____

Speech _____

Are there any Developmental Concerns? ☐ YES ☐ NO _____

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 _____

_____

Please attach an updated immunization record or notarized exemption.

Signature of Health Source: _____

Signed By: _____ Date _____

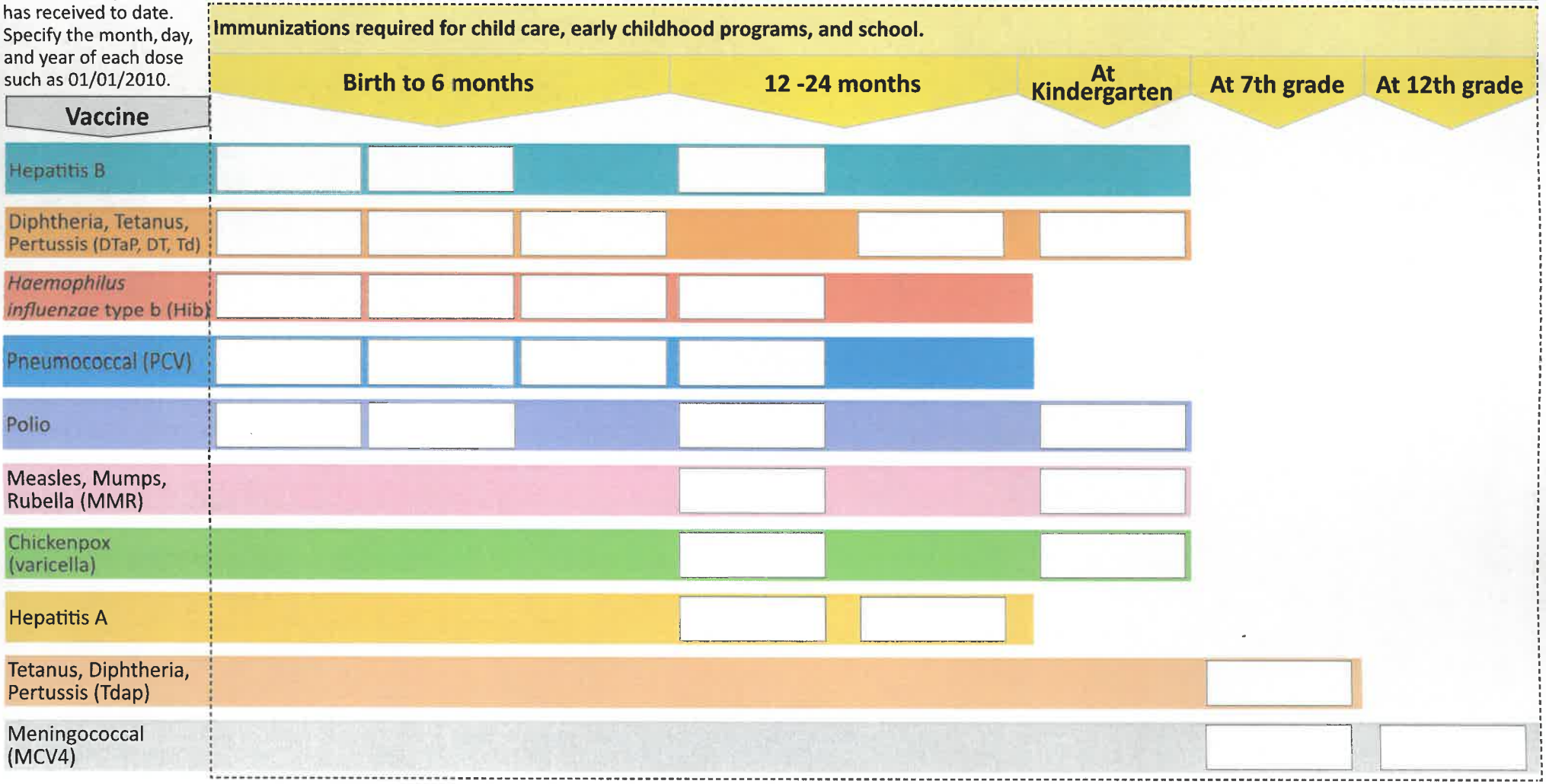
Please return this form to Heartland Christian Academy 9914 Heartland Circle NW Bemidji MN 56601 Office@heartlandbemidji.org Fax: 218-333-0260

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.



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)