



MACALESTER PLYMOUTH
PRESCHOOL

Thank you for choosing Macalester Plymouth Preschool!

We are excited to welcome you and your child to our community and look forward to embarking on our learning adventure together!

In order to secure your child's spot for **SUMMER FUN**, please complete the following forms and return to Macalester Plymouth Preschool at your earliest convenience:

- Enrollment Form**
- Media Release Form**
- Emergency Contact Form**
- Combined Permission Form**
- Health Care Summary**
must be completed by your health care provider
- Child Care Immunization Form**
for the health of our students and staff, we require all students to be vaccinated unless provided with a notarized medical exemption; we do not enroll those with conscientious objections
- Registration Deposit**
\$50 non-refundable deposit; checks can be written to Macalester Plymouth Preschool



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Child's Name _____ Age _____
Address _____ Zip _____
Birth date ___/___/_____ Male Female Nickname _____

Parent/Guardian Name _____
Occupation _____ Location _____ Work Phone _____
Cell Phone _____ Email _____

Other Parent/Guardian Name _____
Occupation _____ Location _____ Work Phone _____
Cell Phone _____ Email _____

Parents' Marital Status _____

Other children in the family:

| Name | Birth Date | School Attending | Grade |
|-------|------------|------------------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Is your child on any medication we need to be aware of? No ___ Yes ___

If yes, please list medications:

Does your child have any allergies we need to be aware of? No ___ Yes ___

If yes, please describe:

Who brings your child to school? _____

Is there anyone NOT allowed to pick up your child? _____

Do you have any immediate concerns you would like the teacher to know about your child?

Please explain:

Please list a local person to call in case of emergency, other than parents:

Name _____ Phone _____

Address _____ Relationship to child _____

About Your Child:

1. Rate your child on a scale from 1–5, 5 being the strongest, in each of the categories below:

Shy _____ Friendly _____ Cautious _____ Outgoing _____

2. Does your child have any unusual fears? No _____ Yes _____

If yes, please describe:

3. What play activities does your child like?

4. Is your child right-handed? _____ Or left-handed? _____

5. Is your child toilet trained? _____ Bladder _____ Bowel _____

6. What does your child say when he/she needs to use the bathroom?

7. Has your child been in other group activities? No _____ Yes _____

If yes, please describe.

8. What do you hope your child will gain from preschool?

9. Is there anything you wish the preschool staff to know about your child?

10. I give Macalester Plymouth Preschool permission to use my child's name, address and phone number to be published in a class list. No _____ Yes _____

I visited Macalester Plymouth Preschool on _____ (date) with / without _____ (name of child you are enrolling). A registration fee is enclosed in the amount of \$150.

I am registering my child for (please choose one):

Week 1 (Monday through Friday, June 10–14, 2024) 9:00 am to 12:30 pm

Week 2 (Monday through Friday, June 17–21, 2024) 9:00 am to 12:30 pm

Signature _____ Date _____



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Dear Parents,

Throughout the year we take many pictures of our preschoolers at Macalester Plymouth Preschool. We use these photos in a variety of ways, including printed media and internet and social media platforms. Please complete this form and return it to us as soon as possible to give us permission to use your child's picture. We will be happy to honor your wishes.

Name of Child(ren) _____

Name of Parent(s) _____

PLEASE SELECT ONE:

1. I/We give permission for Macalester Plymouth Preschool to use photos of my child on website, Facebook or in print publications (brochures or informational pieces about our school). No child names will be used.
2. I/We give permission for Macalester Plymouth Preschool to use photos of my child in any internet or print media publication EXCEPT FOR THE FOLLOWING (check all that apply):
- Facebook. No names will be used.
 - Macalester Plymouth Preschool website. No names will be used.
 - Macalester Plymouth Preschool print publications (brochures, etc). No Names will be used.
3. I/We DO NOT wish for Macalester Plymouth Preschool to use photos of my child on website, Facebook or in print publications such as brochures or school information pieces.

Parent Signature(s) _____ Date _____



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Dear Parents,

In accordance with the STATE OF MINNESOTA, DEPARTMENT OF HUMAN SERVICES licensing standards, the following information must be on file for each child attending preschool. So that we can achieve compliance, please complete the following form and return it to us..

Child's full name: _____

Names and phone numbers of anyone authorized to take your child from the preschool center (i.e. carpool, parents, grandparents):

Names, addresses and phone numbers of the child's **regular** dental and medical care providers:

Names, addresses and phone numbers of the child's **emergency** dental and medical care:

Names, addresses and phone numbers of **two people** to be contacted if the parents can not be reached in an emergency or when there is an injury requiring medical attention:



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Dear Parents,

Throughout the year it has been necessary to use a number of permission forms. To simplify this procedure for us and you, we have combined the forms on to one page. Please complete the following and return it to your child's teacher. Thank you.

Child's full name _____

I give permission for my child to participate in school-sponsored field trips. I understand that I will be notified in advance of the date and destination so that I may withhold my child from any particular trip.

YES NO

I hereby grant permission for my child to use all of the play equipment and participate in all the activities at the preschool center.

YES NO

I hereby grant permission for my child to leave the preschool center premises under proper supervision for neighborhood walks.

YES NO

I hereby grant permission for the Director or Acting Director to take whatever steps that may be necessary to obtain emergency medical care for my child if needed. These steps may include, but are not limited to, the following:

1. Attempt to contact a parent or guardian.
2. Attempt to contact the child's physician.
3. Attempt to contact the parent through any of the persons listed by the parent on the emergency medical form.
4. In the event that #1-3 are unsuccessful, the Director or Active Director may take any of the following actions:
 - a.) call another physician
 - b.) call the paramedics
 - c.) have the child taken to an emergency room

YES NO

Parent Signature _____ Date _____

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> |
|----------------------------------|----------------------------|--|---|
|----------------------------------|----------------------------|--|---|

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.

| Vaccine | Birth to 6 months | 12 - 24 months | At Kindergarten | At 7th grade | At 12th grade |
|---|----------------------|----------------------|----------------------|----------------------|----------------------|
| Hepatitis B | <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"/> |
| <i>Haemophilus influenzae</i> type b (Hib) | <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"/> |
| Polio | <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"/> |
| Chickenpox (varicella) | <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"/> |
| Tetanus, Diphtheria, Pertussis (Tdap) | <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"/> |

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.

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)

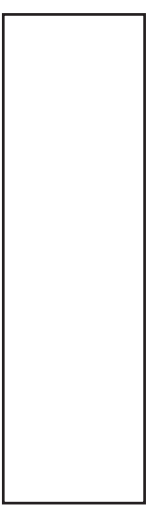
Non-medical exemptions must also be signed and stamped by a notary:

This document was acknowledged before me on _____ (date)

Notary Stamp

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)