Fairmont Christian School

Child Information Sheet

Name of Student \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (first) (middle) (last)

**Names, Address of local emergency contacts and Authorized to transport child from center:**

**(These contacts will be used if there is an injury, illness, or unanticipated event and parents cannot be reached). TWO ADDITIONAL CONTACTS OTHER THAN THE PARENTS ARE REQUIRED BELOW.**

1. Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone numbers: home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_ work \_\_\_\_\_\_\_\_\_\_\_\_

1. Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone numbers: home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_ work \_\_\_\_\_\_\_\_\_\_\_\_

Indicate person(s) your child **may not be released to** under any circumstances without your authorization:

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

**Additional Names of those authorized to pick up**

Child’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone numbers: home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_ work \_\_\_\_\_\_\_\_\_\_\_\_

1. Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone numbers: home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_ work \_\_\_\_\_\_\_\_\_\_\_\_

1. Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone numbers: home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_ work \_\_\_\_\_\_\_\_\_\_\_\_

1. Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone numbers: home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_ work \_\_\_\_\_\_\_\_\_\_\_\_

Parent’s signature & date

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

**Medical and Dental Information**

Name of Primary Medical Caregiver: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Dental Caregiver: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any dietary or medical needs that might impact your child’s experience at Fairmont Christian School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Please list any allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization**

Please circle the appropriate response and sign and date.

I **do / do not** authorize the Director (or qualified staff acting in her charge) to act on my behalf in the event of an emergency if I (and/or my emergency contact person) cannot be reached or am delayed.

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

**Fairmont Christian School Preschool**

**Medication/Authorization Form**

**Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
|  |

*Medication administration at Fairmont Christian School is limited to prescription or nonprescription medications for a specific child and accompanied by written consent of the parent/legal guardian. The written order of the health professional must include the medical reason for the medication, name of the medication, dose, route, when (time or condition), how long the medication is required, and any reactions or side effects that might occur.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Medication** |  |  | **Condition for which medication is prescribed** |  |
| **Dosage** |  |  | **Date of order** |  |
| **Time or conditions of Administration** |  |  | **Route of Administration** |  |
| **Duration of order** |  |  | **Special Directions****Such as “give in juice”** |  |

**Known side effects of medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Plan of management for side effects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Child allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Printed Name of provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian**

 **Medications must be brought to classroom by parent/guardian and given to the Lead Teacher.**

**Medications must be in their original pharmacy or manufacturer-supplied container with a label that includes:**

* The child’s name
* Date medication was issued and when it expires.
* Prescribers name.
* Dose/instructions.
* Pharmacy name and phone number.
* Relevant warnings.

*I give permission for Little Sprouts staff to administer the medication as prescribed above. I give permission for the teacher to contact the prescribing health professional and/or pharmacy where medication was filled, about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.*

 **Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Parent/Guardian Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Early Childhood Immunization Form**

*Must be on file* ***before*** *a child attends any early childhood programs\**

Name Birthdate Date of Enrollment

\*Early childhood programs are defined as programs that provide instructional or other services to support children’s learning and development and:

* Serve children from birth to kindergarten.
* Meet at least once a week for at least six weeks or more during the year.

This includes but not limited to early childhood family education (ECFE), early childhood special education (ECSE), school readiness programs, and other public and private preschool and pre-kindergarten programs.

Minnesota law requires children enrolled in early education programs 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.

Additionally, if a parent or guardian would like to give permission to the early education program to share their child’s immunization record with Minnesota’s immunization information system, they may sign section 3 (optional).

For updated copies of your child’s immunization 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** |
| **Required** (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.) |
| **Diphtheria, Tetanus, and Pertussis** (DTaP, DTP)* 3 doses during 1st year *(at 2-month intervals)*
* 4th dose at 12-18 months
* 5th dose at 4-6 years

*Indicate vaccine type: DTaP or DTP* |  |  |  | 5th dose not requiredon or after the | if 4rd dose was given 4th birthday |
| **Polio** (IPV, OPV)* 2 doses in the first year
* 3rd dose by 18 months
* 4th dose at 4-6 years
 |  |  | 4th dose not requiredon or after th | if 3rd dose was given e 4th birthday |  |
| **Measles, Mumps, and Rubella** (MMR)* Required for children 15 months and older
* 1st dose on or after 1st birthday
* 2nd dose at 4-6 years
 |  |  |  |  |  |
| ***Haemophilus influenzae* type b (Hib)*** 2-3 doses in the first year
* 1 dose required after 12 months or older
* For unvaccinated children 15-59 months, 1 dose is required
* Not required for children 5 years or older
 |  |  |  |  |  |
| **Varicella** (chickenpox)* Required for children 15 months and older
* 1st dose on or after 1st birthday
* 2nd dose at 4-6 years
 |  |  |  |  |  |
| **Pneumococcal Conjugate Vaccine (PCV)*** Required for children age 2 - 24 months
* 3 doses in the first year
* 4th dose after 12 months
* At least 1 dose is recommended for children age 24-59 months in child care
 |  |  |  |  |  |
| **Hepatitis B** (hep B)* 2-3 doses in the first year
* 3rd dose (final dose) by 18 months
 |  |  |  |  |  |
| **Hepatitis A** (hep A)* 2 doses separated by 6 months for children 12 months and older
 |  |  |  |  |  |
| **Recommended** |
| **Rotavirus** (2-3 doses between 2 and 6 months) |  |  |  |  |  |
| **Influenza** (annually for children 6 months or older) |  |  |  |  |  |
|  |  |  |  |  |  |

# Instructions, please complete:

*Box 1 to certify the child’s immunization status*

**Name**

*Box 2 to file an exemption (medical or concientious)*

*Box 3 to provide consent to share immunization information (optional)*

**1. Certify Immunization Status.** Complete A or B to indicate child’s immunization status.

**A. Children who are 15 months or older:**

For children who are 15 months or older and who have received all the immunizations required by law for early childhood programs:

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.

**B. Children who are 15 months or younger:**

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 Parent / Guardian OR Physician / Nurse

Practitioner / Physician Assistant / Public Clinic

 Date

Signature of Physician / Nurse Practitioner / Physician

Assistant / Public Clinic

 Date

1. **Exemptions to Immunization Law.** Complete A and/or B to indicate type of exemption.

# Medical exemption:

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 occured before September 2010, a parent can sign.)

# Conscientious exemption:

No child is required to have an immunization that is con- trary to the conscientiously held beliefs of his/her parent or guardian. However, not following vaccine recommen- dations 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 or- der 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 conscien- tiously 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 (A copy of the notarized statement will be forwarded to the commissioner of health.

Fairmont Christian School

Permission to Photograph

Fairmont Christian School may use photos of children for several purposes.

* I give permission for Fairmont Christian School staff to photograph my child to be used for special projects/crafts, identification of personal belongings, classroom/hallway decorations.
* I give permission for Fairmont Christian School staff to photograph my child for marketing/advertising purposes. This includes, but is not limited to brochures, church annual updates, Fairmont Christian/Small Spouts Facebook page, Fairmont Christian School Website and the local newspaper(s).

\*Only first names and possibly last initials (in the event of two or more children with the same first name) will be displayed.

\* If you choose not to have your child’s phot used for public purposes and they appear in a group phot, we will block their face.

\* We will never publish a picture of your child that portrays them in a negative light.

* I am interested in participating in the See-Saw app in order to get personal updates about my child. These updates could include photos, videos, information updates or glimpses of our day.
* I understand if my child is part of a group picture, other parents may also receive the picture.

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child’s enrollment.

Signed:

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

(Parent or Guardian signature) (Date)

Fairmont Christian School

Permission to Transport

* I give permission for Fairmont Christian School staff to transport my child within Martin County for educational opportunities including field trips, park visits and picnics, library trips and special events. I understand that the staff will inform parents of these outings and in the case of special field trips will provide an additional permission slip. If my child requires a booster seat, I will provide one on the specific day.
* I do not give permission for Fairmont Christian School staff to transport my child and instead will transport them personally.
* I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child’s enrollment.

Signed:

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

(Parent or Guardian signature) (Date)

Hello Families!

We are pleased to announce that we will be pairing each of the children with their own Prayer Partner! Each Prayer Partner has volunteered to regularly pray for your child by name; for their protection, wisdom, strength, and of course, for them to put their faith in Jesus at a very early age, plus so much more. Raising a child is no easy task and God has entrusted each of us with our own precious little ones. We are so excited to have one more person covering each of them in prayer!

Place a check next to each statement you agree to and sign and date at the bottom.

I give my permission for my child to be paired with a Prayer Partner, where my child’s first name only will be shared.

I give my permission for a photo (name tag photo or school portrait) to be shared with my child’s Prayer Partner.

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