Carol Matheys Center for Children & Families

Enrollment Packet Check List

1. Application Form _____

2. Developmental History _____

3. Emergency Form _____

4. Immunization Form _____ (Please sign and date #3 on the back page)

5. Health Care Summary _____

6. Tuition Contract _____

7. Copy of Child's Birth Certificate _____

8. Child Enrollment form/food program _____

9. Household Income Statement/food Program _____

10. Parent Permission form _____

6060 43RD ST. N.
OAKDALE MN 55128
651-777-6668

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Application for Admission

Child's Name _____ Age _____ Birth Date _____

Address _____ Home Phone _____

_____ E-Mail_____

Parent's Name _____ Work Phone _____

Employer _____ Occupation _____

Parent's Name _____ Work Phone _____

Employer _____ Occupation _____

Mom's Cell # _____

Dad's Cell # _____

Marital Status: Married Single Divorced

With whom does your child reside? _____

If parents are not married who has Physical/Legal custody? _____

_____

Are there any court orders or visitation schedules? _____ If yes, please explain and provide copies to Director. _____

_____

Names and ages of siblings or other children living in the home: _____

_____

Other pertinent family information you wish to share with us: _____

_____

Does your child have any allergies, special needs, or illnesses?

_____

_____

Please describe your child in a few words:

_____

Has your child attended any other preschool or childcare programs?

_____

_____

I found this center through the following sources: (circle one)
Internet, Flyer Referral _____ (name)

I would like to enroll my child in the following program:

1. Full Day Preschool_____ Days to Attend: M T W TH F
2. Half Day Preschool 9:30-12:30 _____ Days to Attend: M T W TH F
3. Kindergarten 9:00-3:00 M-F _____
4. School Age Program_____ School _____ Grade_____
Before School_____ or After School _____ Before & After_____

Usual drop off time_____ Usual pick-up time_____

Date I would like my child to begin_____

Please attach a $125 Registration fee to this form and return to the office. No registration will be processed without the fee. Registration is on a first come first serve basis. Space is limited.

Make check payable to: Carol Matheys Center for Children & Families

The undersigned request admission for the above child and hereby agree that the above information is current and accurate.

_____ _____
Parent/Guardian Signature Date

FOR OFFICE USE ONLY

Date reg. received _____ Date to Begin_____
Reg. fee payment _____ _____ Staff Initials _____
$ Check # County: ___ ELS _____

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EMERGENCY FORM

Child's Name _____ Birth Date _____

Parent(s)/Guardian Name

_____ (Mom) Work Phone _____

_____ (Dad) Work Phone _____

Address _____ (Mom) Cell # _____

_____ (Dad) Cell # _____

Email Mom _____ Email Dad _____

Physician Name & Clinic _____

Address _____ Phone # _____

Dentist/Dental Clinic _____

Address _____ Phone # _____

Insurance Information:

Medical Insurance Carrier _____

Policy Number _____ ID # _____

Policy Holder's Name & Date of Birth _____

Emergency Medical Source (Hospital)

_____

Allergies (Include Symptoms and Triggers) _____

_____

Medical Conditions _____

Special Needs _____

Medications your child is currently taking

_____

Child's Name: _____

EMERGENCY CONTACTS

List 3 additional people we can contact in case of an emergency that are also authorized to pick up your child from the center.

1. Name _____
   Relationship to child _____
   Address _____ Cell # _____
   _____ Work # _____

2. Name _____
   Relationship to child _____
   Address _____ Cell # _____
   _____ Work # _____

3. Name _____
   Relationship to child _____
   Address _____ Cell # _____
   _____ Work # _____

Emergency Permission

In the event of a medical emergency concerning my child, I grant permission for the staff at Carol Matheys Center for Children & Families to seek emergency services (911) and for the appropriate qualified medical personal to administer emergency treatment and/or transport my child to the nearest emergency medial source.

In the event of an emergency that requires evacuation of the facility, I grant permission for the staff at CMCCF to transport my child to House of Prayer Church or designated emergency shelter.

_____ _____

Parent/Guardian Signature Date

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CHILD'S DEVELOPMENTAL HISTORY

The following questions are helpful in caring for your child. Please take the time to fill out this history.

Child's Name: _____ Birth Date: _____

SOCIAL RELATIONSHIPS AND DEVELOPMENT

1. **Has your child had experiences playing with other children? _____ if so, in what setting?**
   _____

2. **Has your child previously been in a childcare setting? _____ If so, was it in a home or center? _____**

3. **How do you feel your child will adjust to a new preschool setting?**
   _____

4. **Does your child know any other children at the center?**
   _____

5. **Does your child have any other siblings? _____**
   If so, please list their names and ages.
   _____

6. **How does your child get along with their siblings?**
   _____
   _____

7. **How would you explain your child's personality?**
   _____
   _____

8. What makes your child frustrated or upset?

_____

9. How does your child show this emotion?

_____

10. What is your child's favorite toy and activities?

_____

_____

_____

11. How often is your child read to?

_____

12. How many hours per day does your child have screen time? (TV, Videos, Tablet, Computer, Phone)_____

LANGUAGE & SELF-HELP DEVELOPMENT

1. At what age did your child begin talking? _____
2. What language(s) are spoken in your home? _____
3. Does your child speak English? _____

4. Does your child have any speech delays?

_____

5. Can your child dress him/herself? _____

6. Is your child toilet trained? _____ At what age did your child become trained? _____ Does your child wet the bed at night or during nap time? _____ How often? _____
   - A reminder that children must be toilet trained to attend our programs

7. Does your child communicate when he/she needs to use the bathroom? _____. Does he/she use special words for bowel movements and urination?

_____

EATING & SLEEPING HABITS

1. Doe your child have any food allergies? If so please describe in detail, including symptoms, and when diagonsed. _____
   _____

2. What are your child's favorite foods?
   _____

3. What foods does your child not like?
   _____

4. What time does your child go to bed at night? _____
   What time does your child wake up in the morning? ____

5. Does your child take a nap? _____ How long? _____
   What time? _____

6. Does your child go to bed without problems? _____
   What is the normal bedtime routine?
   _____

7. Does your child sleep in his/her own bedroom?
   _____

8. Does your child have a special blanket or stuffed animal that helps him/her sleep? _____

Please describe your child in a few sentences.

_____
_____
_____
_____

Please describe anything that might be helpful for us to get to know your child and family better?

_____
_____
_____

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 understand 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)

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 _____ _____

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