Family Survey

School Year: _____ **School Name:** _____ **Teacher's Name:** _____

Child's Name: _____ **Parent/Guardian Name(s):** _____

Date: _____

DIRECTIONS

Please answer the following questions.

ABOUT YOUR CHILD

1. Does your child have a nickname that you would like us to use? If so, what is it?

2. What are your child's favorite activities?

3. Does your child have a favorite toy? If so, what is it?

4. What are your child's greatest strengths?

5. What are your child's biggest challenges?

6. What concerns, if any, do you have about your child?

7. What would you most like us to know about your child?

8. What are your greatest hopes for your child?

9. What, if any, health conditions does your child have that require classroom modifications?

The InvestiGator Club™ Prekindergarten Learning System © Robert-Leslie Publishing

ABOUT YOUR FAMILY

10. Does your child have any siblings? If so, how many and what are their ages?

11. Which family members are particularly involved or important in your child's life?

12. Is there any other important information that you would like us to know about your family? What?

ABOUT THE PREKINDERGARTEN EXPERIENCE

13. Has your child attended school in the past? If so, was the experience a positive one? Explain.

14. What does your child look forward to this school year?

15. What, if anything, is your child nervous about concerning this school year?

16. What do you most want your child to learn this school year?

OVERALL

17. What else would you like us to know? Do you have any questions we can answer for you?

STUDENT EMERGENCY REFERRAL

Student's Name_____ Birth date_____
Last First
Home Address_____ Grade/Teacher_____
_____ Home Phone (_____)_____
Father's Name_____ Dad Work Phone (_____)_____
E-mail: _____ Other: _____ Dad Cell Phone (_____)_____
Mother's Name_____ Mom Work Phone (_____)_____
E-mail: _____ Other: _____ Mom Cell Phone (_____)_____

IIf my child becomes ill or injured and I cannot be reached, please call the following people listed in order of preference.
The following are authorized to represent me in making decisions relative to my child's care:

_____(____)_____
Name of person (relationship to student) daytime phone number

_____(____)_____
Name of person (relationship to student) daytime phone number

In case of serious accident/injury/EMERGENCY, Good Shepherd School's procedure will be to contact the parent or guardian at home or at work. If that contact cannot be made, Good Shepherd School personnel will call the physician authorized by the parent or **911** for police and emergency medical assistance.
Name of Clinic/Location:_____Clinic Phone Number :(_____)_____
In case of serious accident/injury/illness and I cannot be reached, I hereby authorize Dr._____ to give the necessary treatment. Call this doctor and/or **911** if necessary.

_____ _____
Parent or Guardian Signature Date

Student Health Information

Student's Name_____ Grade/Teacher_____

Illness: List any illness, surgery, or injury of this past year: _____
Date of last physical examination (month/year): _____ Does child wear: glasses contacts neither
List date and type of any immunization or test given this past year: _____
Is your child allergic to any food, medication, or other substance? Describe: _____

VERY IMPORTANT: **Please complete the following health information, especially if your child has a health concern or takes medication of any kind. Health concerns include, but are not limited to, *asthma, diabetes, seizures, chronic headaches, allergies, physical limitations, ADD/ADHD* or any other medical condition your child sees a physician for.**

I am not aware of any health concerns at this time: _____ (Please initial)

Specify health concern(s): _____
Is child under treatment or taking medication for any concern? Yes No

If yes, please describe or name type of treatment or medication: _____

_____

Does child have any disability? _____ Please explain: _____

A written excuse is required after each absence.
No student will be exempt from physical education, except on the written recommendation from a physician.

Individual Child Care Program Plan for Allergies

Licensed Child Care Centers

The child care center can use this form to document 1) allergy information, 2) medication to respond to an allergic reaction, and 3) emergency contact information for allergy prevention and response. Complete the Individual Child Care Program Plan for Allergies (ICCPP-A) from the allergy information obtained from parents. Documentation of any known allergy must be obtained before the center cares for the child. The ICCPP-A must be available at all times on site, when on field trips, or during transportation. Food allergy information must be readily available to staff in the area where food is prepared and served to the child. All staff who interact with this child must review and follow this plan. **Use a separate form for each allergy, even if the same child has more than one identified allergy.**

Allergy prevention and response requirements are found in MN Statutes, section 245A.41, subdivision 1.

Child Information

Child's Full Name

Child's Date of Birth

Date ICCPP-A was developed

Initial Date

Print Name of Center Representative that developed this ICCPP-A

Signature of Center Representative that developed this ICCPP-A

Allergy Information

1. Describe the allergy. **Use a separate form for each known allergy.**

2. What triggers the allergy?

3. What symptoms may the child display when exposed to an allergen or trigger? (Check all that apply)

- ☐ No history of symptoms or unknown
- ☐ Mouth: Itching; tingling; swelling of lips, tongue or mouth ("mouth feels funny")
- ☐ Skin: Hives; itchy rash; swelling of face or extremities
- ☐ Gut: Nausea; abdominal cramps; vomiting; diarrhea
- ☐ Throat: Difficulty swallowing; hoarseness; hacking cough
- ☐ Lung: Shortness of breath; repetitive coughing; wheezing
- ☐ Heart: Weak or fast pulse, low blood pressure; fainting; pale; blueness
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

What techniques are used to avoid an allergic reaction?

What procedures will be taken to respond to an allergic reaction for this child?

Medications for Responding to an Allergic Reaction- Call 911 if Epinephrine is administered

What medication(s), if applicable, are required for response to an allergic reaction for this child? *Note: If medication provided, refer to Minnesota Rules, chapter 9503.0140, subpart 7 for administration of medication requirements.*

Medication

Dosage

Medication

Dosage

Medication

Dosage

Doctor Information - Call 911 for EMERGENCIES

Doctor's Name

Doctor's Phone Number

Date ICCPP/ICCPP-A Created

Date ICCPP Created	Signature of Center Representative	Position of Center Representative

ICCPP Reviews and Updates

Review

How long has this ICCPP been implemented at the center?

What has worked?

What improvements could be made?

Is there a continued need for an ICCPP for this child? (yes or no)

If yes, what changes to the ICCPP will be made? If no, check here. ☐

Date	Signature of Center Representative Reviewing ICCPP	Signature of Parent / Guardian Reviewing ICCPP

Staff that work with child and have reviewed this ICCPP

Review Date	Print Staff Name	Signature of Staff Reviewing ICCPP

Purpose of this Form: To assist licensed child care centers in planning for the individual program needs of children with special needs as outlined in MN Rules 9503.0065, 9525.004 to 9525.0036, and MN Statutes, section 125A.02, subdivision 1 and 125A.05. The Individual Child Care Program Plan (ICCPP) must be in writing and specify methods of implementation. This plan must be reviewed annually and followed by all staff who interact with the child. The ICCPP must be developed in coordination with reports from a local school district, licensed physician, psychiatrist, psychologist, and with the child's parent or legal guardian, if such reports are available for the child. An ICCPP can also be developed based on the recommendation of consulting physicians, psychiatrists, and psychologists.

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 _____ _____

MS-2083

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)