CHECKLIST FOR PRESCHOOL FORMS 2024-25

Child' Name: _____

The first tuition payment is due July 1st but can be paid at any time prior to that date. (*Disregard if you have already paid for the 2024-25 year in full)

You may use this checklist as you fill out the forms. Place an "X" by the forms you have completed.

_____ Page 1 **Enrollment Information**

_____ Page 2 **Emergency and Medical Information**
*It is a state regulation that **2 LOCAL persons, other than parents,** must be listed for an emergency contact. We need their addresses and phone numbers.
Please sign the Emergency Medical Authorization

_____ Page 3 Social, Emotional & Educational Development

_____ Page 4 Confidential Data Acknowledgment

_____ Page 5 Food Allergy Disclosure Sheet
***Must be completed for ALL children, even those without food allergies.**
If your child has a food allergy, a Child Care Program Plan (backside of Health Care Summary page 7) must be completed by child's physician and signed by a parent/caregiver

_____ Page 6 Child Care Immunization Record
Please complete both sides of this form

_____ Page 7 Health Care Summary/
Individual Child Care Program Plan for Child with Allergies
***This form *must* be filled out and signed by a health care provider.**
Back side only needs to be completed if your health care provider indicates your child has an allergy

_____Page 8 Permission Signatures
Initial next to each item and sign at the bottom

PLEASE RETURN COMPLETED FORMS to WPG BY July 1st

WOODBURY PRESCHOOL
at The GROVE
birth to five programs

Enrollment Information
2024-25

Child's Name (first, middle and last) Birth Date Gender: M F

_____ _____

Address (street address, city, state and zip code)

_____

Preferred first name to use for your child at school_____

Parent/Guardian Name

_____

Parent/Guardian Address (if different)

_____

Parent Cell/ Home Phone Number

_____

E-mail_____

Parent Occupation/Employer

_____

Parent Work Phone Number

_____

Parent/Guardian Name

_____

Parent/Guardian Address (if different)

_____

Parent Cell/Home Phone Number

_____

Email_____

Parent Occupation/Employer

_____

Parent Work Phone Number

_____

Siblings (name, birthdate and age)

_____ / _____ / _____

_____ / _____ / _____

_____ / _____ / _____

Day Care or Nanny Name, Address & Phone Number

_____

Emergency and Medical Information

Emergency Contacts: 2 CONTACTS ARE REQUIRED

Please list two **LOCAL** persons, **OTHER THAN PARENTS,** who may be contacted in case of an emergency, and who are authorized to take your child from the center if parents cannot be reached.

Name	Address	Phone #
1.		
2.		

Doctor's Name, Address, & Phone Number

_____ / _____ / _____

Dentist's Name, Address, & Phone Number

_____ / _____ / _____

Child's Allergies: Doctor must complete back side of Health Care Summary if known allergies – page 7

_____

Allergic Reactions (Mild, Moderate, or Severe – Please Describe) & Treatment

_____

_____

Child's Special Dietary and/or Medical Needs

_____

Health Insurance Company _____

Policy # _____

Name of Policy Holder _____

EMERGENCY MEDICAL AUTHORIZATION

In case of an emergency, I hereby authorize WOODBURY PRESCHOOL at The GROVE personnel to call 911 for an ambulance and/or physician appropriate to the situation to administer treatment to my child.

Signed _____ Date _____

Social, Emotional, and Educational Development

How did you hear about Woodbury Preschool at The Grove? _____

Has your child ever attended a preschool or other group experience? _____

When? _____ Where? _____

Parents' reasons for wanting a preschool/group experience (expectations) _____

_____

Child's play opportunities _____

_____

Interests and strengths of child _____

_____

Child's reaction to change (separation from parents) _____

_____

Comforting ideas for child _____

Check the specific behaviors characteristic of your child:

_____ cries easily	_____ tantrums	_____ tires easily
_____ easy-going	_____ toilet trained (age)_____	_____ dresses independently
_____ fussy eater	_____ sucks thumb	_____ difficult separations
_____ feeds self	_____ naps regularly	

_____ other: _____

Previous conditions such as trauma at birth, premature birth, serious illness, or accident that you would like to share with the teacher: _____

_____

Food likes _____ Food dislikes _____

Dominant hand (right or left) _____

Speech Development _____

What language(s) are spoken in your home?_____

How would you describe the level of direction, reinforcement, and encouragement that your child needs to complete a task?

Low	Average	High
1 2	3 4	5 6

Confidential Data Acknowledgment

Dear Parents/Caregivers,

Please read and sign this document.

In compliance with the Minnesota Government Data Practice Act, WOODBURY PRESCHOOL at THE GROVE has developed the policy that all data on individuals collected, maintained, and used as classified is private and will not be disclosed to any agency or individuals unless prior written consent is obtained from the parents or legal guardian.

I understand that my records are protected under State and Federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise stated. I understand that information is limited to staff whose work assignments reasonably require access to my data within the purposes specified in the service provided.

_____
Name of Child

Kate Beck
Director

_____
Printed Name of Parent or Caregiver

_____
Director's Signature

_____
Signature of Parent or Caregiver

_____
Date

_____
Date

Food Allergy Disclosure Sheet

We have become increasingly aware of the presence of food allergies in the children who attend our program. Some of the most common allergies in children are egg, dairy products, tree nuts and peanuts. Some children are so allergic to peanuts that they are unable to sit next to another child eating a peanut butter sandwich.

It has been our policy to provide the children with a mid-morning commercially prepared snack accompanied by milk, and milk at lunchtime. The labeling on these snacks may or may not be clear about the use of peanut oil or other peanut-based products and ingredients used in their preparation.

In order to provide a healthy environment for your child at school, we need to be informed of any type of **food allergy** your child may have. You also have the option of providing your own snack to lessen the possibility of him/her coming in contact with an allergenic food product.

Please fill out the following information for our records. Thank you.

CHILD'S NAME _____

CLASS NAME, DAY(s) & TIME(s)_____

MY CHILD IS ALLERGIC TO THE FOLLOWING FOOD PRODUCTS: (BE SPECIFIC

_____

REACTION IN PAST HAS BEEN: MILD MODERATE SEVERE

PLEASE SPECIFY HOW CHILD REACTED: _____

_____

RECOMMENDED TREATMENT: **Doctor must complete Allergy Program Plan on backside of Health Care Summary - page 7.**

SPECIAL PRECAUTIONS: (i.e. cannot sit near anyone consuming a particular food, specific ingredients to look for, etc.)

_____

_____MY CHILD **DOES NOT** HAVE A FOOD ALLERGY AND IS SAFE TO CONSUME SNACKS AND DRINKS PROVIDED BY THE PROGRAM.

_____MY CHILD **HAS** A FOOD ALLERGY AND MAY NOT CONSUME SNACKS PROVIDED BY THE CENTER WITHOUT DAILY APPROVAL.

PARENT SIGNATURE _____

DATE _____

Immunization Form

Name_____ Birthdate_____

Immunizations required for child care, early childhood programs, and school.

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.

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)

Health Care Summary

The Health Care Summary must be completed by a health care source and returned by **JUNE 1st** to: WOODBURY PRESCHOOL at The GROVE
7465 Steepleview Road
Woodbury, MN, 55125 or faxed directly to **651-738-4964.**

By completing this form, you are authorizing the staff of WOODBURY PRESCHOOL at The GROVE who have contact with your child to have access to this medical information.

Name of Child _____ Birthdate _____

Address _____ Telephone _____

_____

Parent/Caregiver Printed Name (s) _____

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 meds)? **If yes, complete back side of this form.**

_____

Is a modified diet necessary? _____

Is any condition present that may result in an emergency? _____

What is the status of the child's Vision _____ Hearing _____ Speech _____

Please list below the important health problems. Indicate if you or someone else is following the child for the problem and check which problems require special attention at the center.

Important Health Problems	Followed by you	Followed by other Med. Source (Name)	Requires Special Attention at Center
	/	/	/
	/	/	/

Other information helpful to the school _____

_____

SOURCE OF HEALTH CARE – Clinic or Associates _____

Address _____

Phone _____

Doctor's printed name _____

Doctor's Signature _____

Date _____

Individual Child Care Program Plan
Child with Severe Allergies/Allergies

Child's Name: _____ Date of Birth: ___/___/___

Allergy to: _____

Please check specific Allergy triggers: ☐ Ingestion ☐ Injection ☐ Inhalation ☐ Absorption

Other triggers-specify: _____

Place Child's Picture Here

All symptoms below may be experienced when exposed to an allergen.
(May differ from each exposure and severity of symptoms can quickly change.)
Please select any known symptoms the child may display.

- ☐ Mouth: itching; tingling; swelling of the lips, tongue, or mouth ("mouth feels funny")
- ☐ *Throat: difficulty swallowing; itching and/or a sense of tightness in the throat; hoarseness; hacking cough
- ☐ Skin: hives; itchy rash; swelling of the face or extremities
- ☐ Gut: nausea; abdominal cramps; vomiting; diarrhea
- ☐ *Lung: shortness of breath; repetitive coughing; wheezing
- ☐ *Heart: "weak" or fast pulse; low blood pressure; fainting; pale; blueness
- ☐ No history of symptoms or unknown
- ☐ Other:

***ALL above symptoms can potentially progress to a life -threatening situation!**

TO BE COMPLETED BY HEALTH CARE PROVIDER

If reaction is suspected give **IMMEDIATELY**:

Treatment prescription #1: _____ Dosage: _____

For the described symptoms: _____

Treatment prescription #2: _____ Dosage: _____

For the described symptoms: _____

Precautions and/or possible adverse reactions: _____

Contact emergency medical services whenever epinephrine is used.
(A single dose of epinephrine wears off in 15-20 minutes)

Other pertinent information: _____

Please note: In case of a severe allergy to bee stings, the provider will attempt to quickly remove the stinger by scraping with a fingernail or other object.

Physician's signature: _____ Date: ____/____/____

EMERGENCY PHONE NUMBERS

Parent/Guardian #1: _____
Name Phone # Work # Other #

Parent/Guardian #2: _____
Name Phone # Work # Other #

(See emergency contact information for alternate if parents are unavailable)

Primary health care provider's name: _____ Emergency phone: _____

Specialist's name (if any): _____ Emergency phone: _____

I give my permission for the provider to follow this plan of care prescribed by the physician. I also give my permission to call the health care provider(s) listed above for any additional medical information about my child. I understand that a photo of my child including my child's name and specific allergies and treatment will be posted at the program.

Parent/Guardian's Signature: _____ Date: ____/____/____

2024-25 WOODBURY PRESCHOOL at The GROVE Registration Form – Page 8
Permission Signatures

_____
(Child's Name)

PLEASE INITIAL:

_____ **Parent Handbook Agreement**
I have read and understand the policies and procedures of WOODBURY PRESCHOOL at The GROVE as they are stated in the Parent Handbook. I will cooperate with the center by following the guidelines as they are established.

_____ **Neighborhood Walks**
My child has permission to go on neighborhood walks, as well as to the Royal Oaks Elementary School playground for play. The children will be supervised by an adult at all times.

_____ **Media Consent**
Minnesota guidelines require preschool programs to obtain parental permission allowing children to have their pictures taken while participating in school activities. WOODBURY PRESCHOOL at The GROVE protects the privacy of the students and would not release any student's personal information. WOODBURY PRESCHOOL at The GROVE has my permission to take pictures/videos of my child(ren) while participating in school activities. I understand that if my child's picture were to be published in a newsletter, newspaper, pamphlet, website, or Facebook their name would not be included in the article. **If you have further restrictions, please list them below and make sure your child's teacher is aware of them.**
Any Further restrictions: _____

_____ **Release of Information**
Parents sometimes request a list of their child's classmates to use in planning play dates or birthday parties. WOODBURY PRESCHOOL at The GROVE has my permission to give the following information to other parents in my child's class when requested: child's name, parents' names, phone numbers and e-mail address.

_____ **Diaper Wipes, Diaper Cream, Lotion and Hand Sanitizer**
I give WOODBURY PRESCHOOL at The GROVE staff members permission to use diaper wipes (provided by Woodbury Preschool at The Grove) and diaper cream and lotion (provided by me) on my child as necessary. I will provide diaper cream and lotion and label it with my child's first and last name.

_____ **Emergency Evacuation**
Our school's Emergency Preparedness Plan includes the following provision: Should an emergency evacuation of WOODBURY PRESCHOOL at THE GROVE facilities become necessary, my child may be transported via walking, by a bus, or in a staff member's personal vehicle to a location deemed safe by the director and/or law enforcement officials. Parents will be notified as soon as possible should such an evacuation occur.

_____
Printed Name of Parent or Caregiver

_____
Signature of Parent or Caregiver

_____
Date