ENROLLMENT AGREEMENT

Child's Name:	DOB:

ENROLLMENT INFORMATION

Please complete this Enrollment Agreement accurately and completely, as this information is necessary for Little Scholars Academy Academy to comply with state child care licensing regulations, as well as to understand your child and meet his or her individual needs. Completion of the Enrollment Agreement is required for enrollment at Little Scholars Academy Academy.

CHILD INFORMATION

Last Name		First Name		Middle Name	
Birth Date	Sex o Male o Female	INFANT O	TODDLER O	PRE-SCHOOL O	SCHOOL-AGE O
Home Address		City	State	Zip	Cell Phone
Circle the day(s) of the week care is needed Write time(s) beneath the day it pertains to	Monday	Tuesday	Wednesday	Thursday	Friday

PARENT/GUARDIAN INFORMATION

PRIMARY PARENT/GUARDIAN		DOB	Relationship to Child
How do you prefer to be reached	Maiden Name (if applicable)		**NOTE:** Personal information is used for verification of identification.
Home Address	City	State	Zip
Cell Phone	E-Mail Address		
Cell Phone Provider	Employer		
Work Phone	Employer Address		

SECONDARY PARENT/GUARDIAN		DOB	Relationship to Child
How do you prefer to be reached	Maiden Name (if applicable)		**NOTE:** Personal information is used for verification of identification.
Home Address	City	State	Zip
Cell Phone	E-mail Address		
Cell Phone Provider	Employer		
Work Phone	Employer Address		

EMERGENCY CONTACT AND RELEASE PERSONS – OTHER THAN PARENTS/GUARDIANS

Please list below the names and contact information of those persons other than yourself you hereby authorize to pick up your child from the school. Emergency contacts must not include people residing in your household but must be friends or other family members who do not live with you and are familiar with your child. Little Scholars Academy Academy will only release your child to adults you designate as authorized. It is our policy to ask all unfamiliar adults for photo identification. If possible, please notify the school if someone other than the primary or secondary parent/guardian will be picking up your child on a given day. A minimum of two emergency contacts are required.

Emergency Contact/Authorized Person #1	Relationship to Child	Cell Phone	Work Phone
Home Address City State Zip	E-Mail Address		

Emergency Contact/Authorized Person #2	Relationship to Child	Cell Phone	Work Phone
Home Address City State Zip	E-Mail Address		

Emergency Contact/Authorized Person #3	Relationship to Child	Cell Phone	Work Phone
Home Address City State Zip	E-Mail Address		

Emergency Contact/Authorized Person #4	Relationship to Child	Cell Phone	Work Phone
Home Address City State Zip	E-Mail Address		

ENROLLMENT AGREEMENT

HEALTH AND DEVELOPMENTAL HISTORY

Child's Name:	DOB:

GENERAL HISTORY

1. Has your child had previous child care experience? If yes, please list location(s) of previous child care experience: ______
2. What is your child's favorite activity/toy? ______
3. How do you comfort your child? (i.e., use of pacifier, blanket, stuffed animal, physical touches such as hugs, etc.) ______
4. Does your child have any special needs that the staff should be aware of? Please attach a copy of your child's IEP, if applicable.
   If yes, please explain: ______

DAILY ROUTINES – INFANTS/TODDLERS

1. Does your baby cry when going to sleep?
2. Does your baby need a pacifier?
3. Is your baby: o breast fed o bottle fed What type of bottle? ______ What type of nipple? ______
4. Does your baby have any special feeding requirements? If yes, please indicate: ______
5. What is your child's present eating schedule? List type and amount of food:

Solid Foods		Formula/Breast Milk/Milk
Breakfast		
Lunch		
Snack		

DAILY ROUTINES – TODDLERS/PRESCHOOLERS

1. What is your child's present sleeping schedule? Night time ______ to ______ AM Nap ______ to ______ PM Nap ______ to ______
2. Does your child need a blanket or toy for sleeping?

TOILETING

1. How frequently does your child have a bowel movement? ______
2. Is your child toilet trained?
3. What word does your child use for urination? ______ Bowel movement? ______
4. Does your child use a potty-chair?
5. Does your child frequently have a diaper rash? If yes, how is it treated? ______

Please attach additional pages to list any additional comments you may have relating to any aspects of your child's health or developmental history.

MEDICAL INFORMATION

ALLERGIES

1. My child does have food or environmental allergies, asthma, or special food accommodations as determined by a physician or religious preferences.
   If yes, please continue on to question 2. If no, please go on to the next section.
2. My child has allergies (please check all that apply). If checked, please fill out Individual Allergy Action Plan, along with appropriate prescription and non-prescription medication release forms (Long-Term Prescription Medication Release and Authorization for Over-the-Counter Allergy Medication).
3. My child has asthma. If yes, please fill out Individual Asthma Action Plan, along with appropriate prescription and non-prescription medication release forms (Long-Term Medication Release, etc.).
4. My child has special diet accommodations (including allergies, food intolerance, and/or cultural/religious preferences). If yes, please complete Special Foods Needs and/or Special Diet Statement.

MEDICAL PROVIDERS

Primary Care Clinic	Physician Name Practice Phone		
Address	City	State	Zip
Primary Dentist	Phsycian Name Practice Phone		
Address	City	State	Zip

Primary Parent/Guardian Signature:	*Date:*	*Secondary Parent/Guardian Signature:*	*Date:*

Little Scholars Academy

EMERGENCY CARD

CHILD'S NAME			BIRTH DATE
ADDRESS	CITY	STATE	ZIP

PARENT/GUARDIAN	PHONE NUMBERS	
1.	Work:	Cell: Home:
EMAIL ADDRESS		
2.	Work:	Cell: Home:
EMAIL ADDRESS		

THE FOLLOWING INFORMATION IS REQUIRED BY THE DEPARTMENT OF HUMAN SERVICES

EMERGENCY CONTACT/AUTHORIZED PICKUP
***(MUST BE DIFFERENT FROM PARENT/GUARDIAN)**

1.	NAME			
	RELATIONSHIP			PHONE NO.
	ADDRESS	CITY	STATE	ZIP
2.	NAME			
	RELATIONSHIP			PHONE NO.
	ADDRESS	CITY	STATE	ZIP

PHYSICIAN			PHONE NO.
ADDRESS	CITY	STATE	ZIP
PREFERRED HOSPITAL			
ALLERGIES			
DENTIST			PHONE NO.
ADDRESS	CITY	STATE	ZIP
MEDICATIONS			
OTHER SIGNIFICANT MEDICAL INFORMATION			

I give permission to Little Scholars Academy to make whatever emergency (e.g., first aid, disaster evacuation) measures are judged necessary for the care and protection of my child while under the supervision of the school.

In case of a medical/dental emergency, I understand that my child will be transported to an appropriate medical facility by the local emergency unit for treatment if the local emergency resource (police, rescue squad) deems it necessary.

It is understood that in some medical situations, the staff will need to contact the local emergency resource before the parent, child's physician, and/or other adult acting on the parent's behalf.

By signing this form, I authorize Little Scholars Academy to release any information pertaining to my child to persons listed as an emergency contact or authorized pickup.

SIGNATURE________________________________ DATE________________
PARENT OR 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 ____________

MS-2083

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								
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)

PROVIDERS CHOICE

Annual Family CACFP Enrollment Form

Center Name:	Little Scholars Academy	First Day in Care:	

STEP 1 List all children in the household

First Name	Last Name	Date of Birth	Enrolled in center?	Foster child?	Hours in Care: Arrive	Hours in Care: Leave	Normal Days in Care: M	Tu	W	Th	F	Sa	Su	Normal Meals Received: B	AM	L	PM	D	EV	Ethnicity*	Race**

Ethnicity* Optional to complete — H: Hispanic or Latino -OR- N: Not Hispanic or Latino

Race** Optional to complete — I: American Indian or Alaskan Native, A: Asian, B: Black or African American, P: Native Hawaiian or other Pacific Islander, W: White

STEP 2 Infants

Infant's Name: ______ ☐ Parent will provide more than 1 food item per meal/snack and decline the CACFP

☐ Center will provide formula — The type of iron-fortified infant formula this center offers: ______

☐ Parent will provide breastmilk — ☐ Parent will provide iron-fortified infant formula. *Specify brand & type:* ______

STEP 3 Do any household members currently participate in: ☐ SNAP? ☐ MFIP? ☐ FDPIR? If YES, Case Number: ______

STEP 4 Complete if you do not have a case number.

Adults – Full Name List all adult household members even if they don't receive income.	Gross Pay: How Much?	Gross Pay: How Often?	Farm or Self-Employment: How Much?	Farm or Self-Employment: How Often?	Public Assistance, Child Support, Alimony: How Much?	Public Assistance, Child Support, Alimony: How Often?	All Other Incomes: How Much?	All Other Incomes: How Often?
	$		$		$		$	
	$		$		$		$	
	$		$		$		$	
					Child Income		$	

How Often — W: Weekly, B: Bi-Weekly (every other week), 2: Twice a month, M: Monthly, Y: Yearly

STEP 5

I certify (promise) that all information on this form is true and that all income is reported. I understand this information is given in connection with receipt of federal funds and that officials may check the information. I understand that if I purposely give false information, I may be prosecuted under applicable federal and state laws.

Print Name ______ Last 4-digits of Social Security Number SSN (if STEP 4 is completed): ______ No SSN ☐

Signature ______ Date ______ Phone ______

Address ______ City, State, Zip Code ______

Email ______

SPONSOR USE ONLY

☐ Free (A) – Foster ☐ Free (A) – Case Number ☐ Free (A) - Income ☐ Reduced (B) - Income ☐ Paid (C) Income: How Much ______ How Often ______ HH Size ______

Effective Dates ______ TO ______ Signature ______ Date ______ 2nd Approval ______