

2017-2018 **PRESCHOOL** STUDENT EMERGENCY INFORMATION DATA

Date: _____

Student: _____
 (Last name) (First Name) (Middle Name) Grade Birth date
 Address: _____ City _____ Zip Code _____
 Mother's Name: _____ Father's Name: _____
 Mother's Home Phone _____ Father's Home Phone: _____
 (Work #) _____ (Work #) _____
 Business Name: _____ Business Name: _____
 (Cell #) _____ (Cell #) _____
 (E-mail) _____ (E-mail) _____

My child MAY BE released to the following people:

Name: _____ Home () _____ Work () _____
 Address: _____
 Relationship to Child: _____
 Name: _____ Home () _____ Work () _____
 Address: _____
 Relationship to Child: _____

My child MAY NOT be released to the following people:

Doctor: _____ Clinic: _____ Phone: _____
 Address: _____ City: _____ Zip Code: _____
 Dentist: _____ Clinic: _____ Phone: _____
 Address: _____ City: _____ Zip Code: _____

Hospital of Choice: _____

PLEASE COMPLETE THE OTHER SIDE OF THIS CARD.

ANNUAL HEALTH INFORMATION

*If your student has any conditions which might result in an emergency during the school day, i.e. asthma, diabetes, bee stings, severe allergy, seizures, etc., please request "Emergency Action Plan" form from the school nurse. Fill out the form and return it to the office as soon as possible. If there is a health concern you prefer to discuss privately, please contact the school nurse.

Please check any conditions which apply to this student:

____ Allergies (Specify): _____
 ____ *Allergies-SEVERE _____ Requires epi-pen
 ____ *Asthma _____ MD Diagnosed _____ Uses Inhaler _____ Nebulizer
 ____ *Bee Sting Allergy _____ Requires epi-pen _____ Requires oral meds
 ____ *Diabetes
 ____ *Epilepsy/Seizures
 ____ Frequent earaches/infections _____ PE tubes inserted _____ (year)
 ____ Frequent headaches: Type _____
 Symptoms: _____
 ____ Heart disease/condition (Specify) _____
 ____ Orthopedic problems (Specify) _____
 ____ Serious Accident/Concussions: _____
 ____ Special Diet _____
 ____ On medication (Specify) _____
 ____ At home ____ At school (**Medication Form Required**)

***Requires Emergency Plan or accommodations in school**

In case of a minor accident or illness, where it seems advisable to dismiss a student from school, the procedure will be:

4. Contact the parent at home, work or cell.
5. Contact the other designated persons to care for your child until you can be reached.

If a student is seriously injured or ill and requires medical attention or hospital treatment, our procedure in addition to the above will be:

6. Call 911. Under certain circumstances, an ambulance may transport your child to the designated hospital at the parent's expense.

Parent/Guardian Signature _____

Date: _____

Child Care Immunization Form

Must be on file before a child attends child care

Name _____ Birthdate _____

Date of Enrollment _____

Minnesota law requires children enrolled in child care 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.

For updated copies of your child's vaccination 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 (x)	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 required if 4rd dose was given on or after the 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 required if 3rd dose was given on or after the 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 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)						

Name _____

Instructions, please complete:

Box 1 to certify the child's immunization status

Box 2 to file an exemption (medical or conscientious)

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 child care:

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.

Signature of Parent / Guardian OR Physician / Nurse Practitioner / Physician Assistant / Public Clinic

Date

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 Physician / Nurse Practitioner / Physician Assistant / Public Clinic

Date

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

A. 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 occurred before September 2010, a parent can sign.)

B. Conscientious exemption:

No child is required to have an immunization that is contrary to the conscientiously held beliefs of his/her parent or guardian. However, not following vaccine recommendations 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 order 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 conscientiously 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.)

Are Your Kids Ready?

Minnesota's Immunization Law

Immunization Requirements

Use this chart as a guide to determine which vaccines are required to enroll in child care, early childhood programs, and school (public or private).

Find the child's age/grade level and look to see if your child had the number of shots shown by the checkmarks under each vaccine. The table on the back shows the ages when doses are due.

Birth through 4 years Early childhood programs & Child care	Age: 5 through 6 years ^③ For Kindergarten	Age: 7 through 11 years For 1 st through 6 th grade	Age: 12 years and older For 7 th through 12 th grade
Hepatitis A (Hep A) ✓			
Hepatitis B (Hep B) ✓✓✓	Hepatitis B ✓✓✓	Hepatitis B ✓✓✓	Hepatitis B ^⑦ ✓✓✓
DTaP/DT ✓✓✓✓	DTaP/DT ^④ ✓✓✓✓✓	✓✓✓tetanus and ^⑥ diphtheria containing doses	✓Tdap ^⑧ & at least 2 tetanus and diphtheria containing doses
Polio ✓✓✓	Polio ^⑤ ✓✓✓✓	Polio ✓✓✓	Polio ✓✓✓
MMR ✓	MMR ✓✓	MMR ✓✓	MMR ✓✓
Hib ✓			
Pneumococcal ^① ✓✓✓✓			Meningococcal ^⑨ ✓ & booster
Varicella ^② ✓	Varicella ^② ✓✓	Varicella ^② ✓✓	Varicella ✓✓

Immunizations recommended but not required:

Rotavirus For infants	Influenza Annually for all children age 6 months and older	Human papillomavirus At age 11-12 years
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- ① Not required after 24 months.
- ② If the child has already had chickenpox disease, varicella shots are not required. If the disease occurred after 2010, the child's doctor must sign a form confirming disease.
- ③ First graders who are 6 years old and younger must follow the polio and DTaP/DT schedules for kindergarten.
- ④ Fifth shot of DTaP not needed if fourth shot was after age 4. Final dose of DTaP on or after age 4.
- ⑤ Fourth shot of polio not needed if third shot was after age 4. Final dose of polio on or after age 4.
- ⑥ Need proof of at least three tetanus and diphtheria containing doses. If up to date on DTaP/DT series, no additional doses needed.
- ⑦ An alternate two-shot schedule of hepatitis B may also be used for kids age 11 through 15 years.
- ⑧ One dose of Tdap is required beginning at 7th grade. Also need proof of at least two tetanus and diphtheria containing doses (DTaP/DT/Td). If a child received Tdap prior to 7th grade, another dose of Tdap is not needed.
- ⑨ One dose is required beginning at 7th grade. The booster dose is usually given at 16 years.

Exemptions

To enroll in child care, early childhood programs, and school in Minnesota, children must show they've had these immunizations or file a legal exemption.

Parents may file a medical exemption signed by a health care provider or a non-medical exemption signed by a parent/guardian and notarized.

Looking for Records?

For copies of your child's vaccination records, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-3980.