Immanuel Lutheran School
Emergency Call Form

Student's Name: _____

Mother's Name: _____

Address: _____

Home Phone #: _____ Cell #: _____

Place of Work: _____

Work Phone #: _____ Email: _____

Father's Name: _____

Address: _____

Home Phone #: _____ Cell #: _____

Place of Work: _____

Work Phone #: _____ Email: _____

Family Physician: _____

Phone #: _____ Location: _____

People to contact if we are unable to reach you:

1. _____ Phone #: _____
2. _____ Phone #: _____

People authorized to pick up your child after school:

1. _____ Phone #: _____
2. _____ Phone #: _____

People **NOT** authorized to pick up your child:

_____

Does your child have any medical need of which we should be aware in case of an emergency?
Yes/No
If yes, please explain. _____

_____

Medical Treatment Permission: If you and the above physician cannot be reached in an emergency, and if in the judgment of the school authorities, immediate medical and/or hospital attention is needed, do you authorize responsible authorities to take your child, properly accompanied, to an available hospital or physician?

Yes _____ No_____ Date: _____ Signature: _____

Initial for upcoming school-year:

3PK_____ 4PK_____ K_____ 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ 8_____

Questionnaire for the Master Record

The school must keep a record of significant information about your child. Please assist by filling in this questionnaire and returning it to the school as soon as possible.

Date _____

Name of pupil _____
(Last) (First) (Middle)

Address _____
(Street) (City, State, Zip)

Telephone _____ Pupil's Sunday School _____
(Name, City & State)

Date of Birth _____ Place of Birth _____ Adopted (Yes or NO) ____
(Month, Day, & Year) (City & State)

Date of Baptism _____ Church where baptized _____
(Month, Day, & Year) (Name, City & State)

Provide informations on immunizations as to date, type, and result.
If the child has had any of the diseases listed, indicate the age at which he/she had the disease and any organic weakness which resulted. Use other side or extra sheet to give information about other serious diseases.

IMMUNIZATIONS			DISEASES		
DATE	TYPE	RESULT	AGE	TYPE	EFFECT
				Chicken pox	
				Diphtheria	
				Measles	
				Scarlet Fever	
				Tuberculosis	
				Whooping cough	

List the schools which the pupil previously attended. Indicate the grade level.

Grade/s	School & Location
_____	_____
_____	_____
_____	_____

Pre K & K Only

HEALTH CARE SUMMARY

(to be completed by health care provider and submitted with kindergarten registration materials)

Child's Name: _____ Birthdate: _____

Parents or guardian: _____

Does this child have any allergies (including allergies to medications)? Yes No

If yes, please list: _____

Is a modified diet necessary? Yes No

If yes, please explain: _____

Is any condition present that may result in an emergency? Yes No

If yes, please explain: _____

Date of physical exam: _____ Vision: R_____ L_____

Height: _____ Weight: _____ Hearing: R_____ L_____

Speech: _____

Please list below any important health concerns:

Important health concerns	Followed by whom (name)	Requires attention at school?
_____	_____	_____
_____	_____	_____

Other information helpful to the teachers: _____

_____

Health Care Provider: _____

Address _____ Phone: _____

Health Care Provider Signature _____

REQUEST FORM FOR
DISTRICT PUPIL HEALTH SERVICES

School Year Ending June

The State of Minnesota has authorized local public school districts to allow pupils attending a nonpublic school, (includes home schools), established and operating within the school district boundaries, access to the existing district Pupil Health Services program. These services must be requested by, or on behalf of, the pupil **no later than SEPTEMBER 15.**

Please indicate, by placing an "X" in the appropriate box below, whether or not you request these items this school year.

Pupil's Name: _____ Grade Level: _____

Name of School: _____

☐ I do request that the district's Pupil Health Services program be made available to the above pupil this school year.

☐ I **do not** wish to request Pupil Health Services this school year.

_____ _____

Signature of Pupil, Parent, or Guardian Date

PLEASE RETURN SIGNED FORMS TO THE NONPUBLIC SCHOOL WHEN COMPLETED.

PUPIL IMMUNIZATION RECORD

FOR SCHOOL USE ONLY
( ) Complete; booster required in _____
( ) In process; 8 mos. expires _____
( ) Medical exemption for _____
( ) Conscientious objection for _____

Name _____ Birthdate _____ Student Number _____

Minnesota Statutes Section 121A.15 requires children enrolled in a Minnesota school to be immunized against certain diseases, allowing for certain specified exceptions. This form is designed to provide the school with information required by the law and will be available for review by the Minnesota Department of Health and the local community health board.

Enter the MONTH, DAY, and YEAR for all vaccines the pupil received. DO NOT USE (✓) or (✗).

Type of Vaccine	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
Diphtheria, Tetanus, and Pertussis (DTaP, DTP)					
Diphtheria and Tetanus (DT) - pediatric formulation (<7 yrs)					
Tetanus and Diphtheria (Td) - adult formulation (7 yrs)					
Polio (IPV, OPV)					
Measles, Mumps, and Rubella (MMR) (minimum age: 12 mos)					
Hepatitis B (hep B) *					
Varicella (chickenpox)**					
Pneumococcal conjugate (PCV)***					
Haemophilus influenzae* type b** (Hib)					

* Hepatitis B is required for kindergarten and 7th grade.
** Varicella vaccine will be required starting fall 2004.
*** PCV and Hib vaccines are recommended only for children through age 4 years.

Note for school personnel: Be sure to initial and date any new information that you add to this form after the parent/guardian submits it. Also, record combination vaccines (e.g., DTaP+Hib, Hib+HBV) in each applicable space.

Indicate immunization status and source of above information by choosing one of the following:

☐ I certify that this student has received all immunizations required by law.

_____
Signature of parent/guardian or physician/public clinic Date

☐ I certify that this student has received at least one dose of vaccine for diphtheria, tetanus, and pertussis (if age-appropriate), polio, hepatitis B (K + 7th), varicella (K + 7th), measles, mumps, and rubella and will complete his/her diphtheria, tetanus, pertussis, hepatitis B, and/or polio vaccine series within the next 8 months. The dates for which the remaining doses are to be given are:

_____

_____
Signature of parent/guardian or physician/public clinic Date

Legal Exemptions to Minnesota School Immunization Law

- Students 7 years of age or older do not need pertussis vaccine.
- Students 18 years of age or older do not need polio vaccine.
- **Medical exemption:** No student is required to receive an immunization if they have a medical contraindication or laboratory evidence of immunity. To receive a medical exemption, a physician must sign the following statement:

I hereby certify that immunization is contraindicated for medical reasons or that laboratory confirmation of adequate immunity exists for the following immunizations

_____

_____
Signature of physician Date

- **Conscientious exemption:** No student is required to have an immunization which is contrary to the conscientiously held beliefs of his/her parent or guardian. To receive this exemption, a parent or legal guardian must complete and sign the following statement and have it notarized:

I hereby certify by notarization that immunization for my child is contrary to my conscientiously held beliefs. Indicate vaccine(s):

_____

_____
Signature of parent or legal guardian Date

Subscribed and sworn to before me this _____ day of _____ 20_____

_____
Signature of notary

Special Exceptions for DTP, Td, Polio, and Hep B

- **Children less than 7 years of age:** The 5th dose of DTaP/DTP/DT (similarly, the 4th dose of polio vaccine) is not necessary if the 4th DTaP/DTP/DT (3rd dose of polio) was administered after the 4th birthday.
- **Children 7 years of age and older:** A history of 3 doses of DTaP/DTP/DT/Td and 3 doses of polio vaccine meets the minimum requirements of the law.
- **Students in grades 7-12:** A Td booster at age 11 years or later is not required for students in grades 7-12 whose most recent Td was given after their 7th birthday but before their 11th birthday. Instead, it will be required 10 years after the date of the most recent dose. Enforcement of theTd booster requirement will be reinstated in the fall of 2004 for all 7th-12th graders.
- **Students 11-15 years of age:** A 3rd dose of hepatitis B vaccine is not required for those students who provide documentation of the alternative 2-dose schedule.

IC#140-0155 HE #01574-03 (MDH, 9/03)

Type 1 Field Trips

Student's Name _____

I/We understand that this parent general approval form is for Type 1 Field Trips. Type 1 trips are all walking trips (Chapel, etc..) of one mile or less. Does your son or daughter have special health problems or handicapping conditions which will require individual monitoring on field trips?

_____ yes _____ no

If yes, what is the problem and what special consideration should be given to your child?

_____

_____

_____

I/We authorize Immanuel Lutheran School – Courtland to take _____ on Type 1 Field Trips during the _____ school year.

Date_____ _____

Signature of Parent or Guardian

Telephone: Home _____ Work _____

Cell: _____

PUBLICITY .....

Permission is granted to Immanuel Lutheran School to publicize events and activities in which my child is a participant. .

YES NO

____ ____ My child's photo may be used on our school's web site.

____ ____ My child's photo may be used for newspaper or other public media.

Child(ren)'s name(s)_____

Parent's signature_____

Date _____