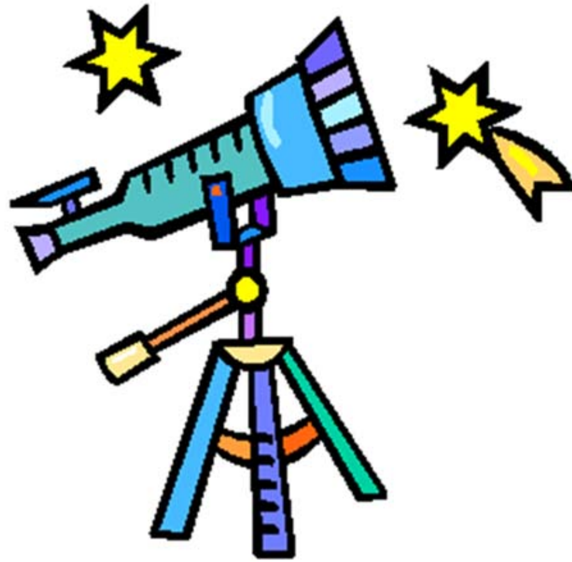
DISCOVERY KIDS



Registration Packet

For Infants, Toddlers, Preschool and School Aged Care

Address:
Benson Public Schools
1400 Montana Avenue
Benson, MN 56215

Phone: (320) 843-4545
Fax: (320) 843-2262

Updated 9/2017

intentionally left blank.

DISCOVERY KIDS

Child's Registration Record

General Information

Child's Name: ________________________ Date of Birth ____________

Address: ________________________ Phone: ____________

Mother's Name: ________________________

Address: ________________________

Phone: (h) ____________ (c) ____________

Place of work: ________________________ Phone: ____________

Email Address: ________________________

Father's Name: ________________________

Address: ________________________

Phone: (h) ____________ (c) ____________

Place of work: ________________________ Phone: ____________

Email Address: ________________________

Medical and Dental Information

Physician Name: ________________________ Phone: ____________

Health Care Facility Name: ________________________

Health Care Facility Address: ________________________

Health Concerns: ________________________

____

____

Dentist Name: ________________________ Phone: ____________

Dentist Facility Name: ________________________

Dentist Address: ________________________

Emergency Contacts (who may be contacted in case parents cannot be reached)

Name: ________________________ Phone: ____________

Address: ________________________

Name: ________________________ Phone: ____________

Address: ________________________

Pick Up Authorization

The following have permission to pick up my child from Discovery Kids.

Name: ______________________________ Phone: ________________

Name: ______________________________ Phone: ________________

Name: ______________________________ Phone: ________________

Name: ______________________________ Phone: ________________

The following are unauthorized and CANNOT pick up my child (documentation required)

Name: ______________________ Name: ______________________

Permissions

_____ I give my permission to Discovery Kids staff to provide appropriate care for my child in an emergency, in the event I cannot be reached or am delayed.

_____ I give my permission to Discovery Kids staff to administer the following products according to manufacturers' instructions or as instructed by a health professional:

Items as supplied by parents:

_____ Diaper Wipes

_____ Diaper/Rash Ointment

_____ Pain Reliever

_____ Sunscreen

_____ Diapers

_____ Chapped Lip Remedies

_____ Teething Gel

_____ Insect Repellant

_____ I have completed the required Health Care Summary and Immunization Forms.

_____ I give my permission for my child to be photographed for center curriculum, projects and newspaper articles.

_____ Your child will be participating in Teaching Strategies GOLD, an assessment tool. This is a non-standardized assessment that measures development progress in children birth through Kindergarten and is part of our preschool curriculum. Parents will receive copies of this information during parent conferences. I give my child permission to participate.

_____ I have been offered the Discovery Kids Program Policies, have been offered a tour of the facility and have been made aware of the conference scheduled days.

______________________________ ________________

Signature Date

Classroom Information

Child's Name: ____ Date of Birth _______________

Days of the week and hours your child will attend Discovery Kids

Monday: ________________________________ Tuesday: ____________________________

Wednesday: _____________________________ Thursday: ___________________________

Friday: __________________________________

Date you would like to start at Discovery Kids: ____

List any allergies (food or medical) your child has: ______________________________________

____

Please list any special needs or developmental concerns (speech, hearing, walking, etc.) _____

____

Are there any family circumstances we need to know about to provide appropriate care for your child? ____

____

Are there any family traditions and customs you would like to share with us? _____________

____

How does your child express anger and/or frustration? _________________________________

____

When your child is upset, what works to comfort him/her? ______________________________

____

Please list any fears your child might have. ____

____

What are your child's favorite activities? ____

____

Does your child have special food likes or dislikes? ______________________________________

____

Does your child have a development, emotional or physical disability? _______ If yes, an Individual Child Care Program Plan will be developed between the parent and the Director.

Questions for Infants, Toddlers and Preschoolers (please complete as is pertinent):

Is your child toilet trained: _______ If yes, how does your child indicate he/she has to use the bathroom? ____

Does your child require help with feeding, toileting, dressing, or other self-help skills? _____
____

Does your child take a nap? ______ If yes, explain how long their nap usually lasts and if they use a favorite blanket, etc.: ____

Describe your child's eating schedule. ____
____

How does your child communicate his/her needs to you? ____________________________
____

What are your child's self-comforting habits and methods? __________________________
____

Parents of infants are also required to review and complete Safe Sleep Documentation which will be included in the registration information received from Discovery Kids.

I understand other fees I may be charged include:

- A non-refundable registration fee of $20.00 per family.
- A $25.00 charge for any checks returned for non-sufficient funds.
- A $10.00 late fee for any payments not paid before the next billing cycle.
- A late fee of $5.00 for every 5 minutes past 6:30 pm.
- Certain classroom enrichment activities offered through outside vendors

Notice of withdrawal from the Center must be given two weeks in advance of the last scheduled day of enrollment.

I understand that any changes in this agreement must be negotiated between the Center Director and myself at least two weeks prior to the effective date.

The Discovery Kids staff has my permission to take my child on walks and field trips, using school bus transportation.

Seat belts will be used whenever vans are taken and when needed, I will provide a car seat or booster seat for my child.

I authorize Discovery Kids to care for my child. I will keep Discovery Kids current on all relevant information regarding my child. I will read and abide by the policies outlined in the Parent Handbook and the terms of this agreement.

______________________________________ ____________________

Signature Date

DISCOVERY KIDS

INFANTS AND TODDLERS ONLY FROM THIS POINT FORWARD

Health Care Summary and Immunization Forms

The following two documents must be completed in full and returned to Discovery Kids prior to your child starting with the program.

These forms are supplied by the Minnesota Department of Human Services and are required.

The Health Care Summary must be filled out and signed by your child's physician; we are not allowed to accept forms generated by a medical center.

The Child Care Immunization Form is a two page document; be sure to complete both sides.

Page 1: you may use the print out received from your clinic to complete this page. No signature necessary.

Page 2: A signature is *required* in one of the four boxes. Please read each box to see which one best fits the age and immunization history of your child.

*If you are choosing Box 2A (medical exemption) a physician must sign and date.

*If you are choosing box 2B (conscientious exemption) you must have your signature notarized.

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

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 (×)	**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 4th 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 concientious)

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 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 younger than 15 months:

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 occured 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.)