

Fax # 952-891-3469

## 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** \_\_\_\_\_

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.

Birth to 6 months

12 -24 months

At Kindergarten

At 7th grade

At 12th grade

## Vaccine

Hepatitis B	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>Haemophilus influenzae</i> type b (Hib)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pneumococcal (PCV)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Polio	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Measles, Mumps, Rubella (MMR)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Chickenpox (varicella)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hepatitis A	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Tetanus, Diphtheria, Pertussis (Tdap)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Meningococcal (MCV4)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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:

- 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.
- 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.

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.

Birth to 6 months

12 -24 months

At Kindergarten

At 7th grade

At 12th grade

## Vaccine

Hepatitis B	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>Haemophilus influenzae</i> type b (Hib)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pneumococcal (PCV)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Polio	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Measles, Mumps, Rubella (MMR)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Chickenpox (varicella)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hepatitis A	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Tetanus, Diphtheria, Pertussis (Tdap)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Meningococcal (MCV4)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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:

- 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.
- 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.

## Health Information Form

Child's Name \_\_\_\_\_ Birth date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

Zip \_\_\_\_\_ Phone Number \_\_\_\_\_

Date of last physical examination \_\_\_\_\_

Are all immunizations current for this child? \_\_\_\_\_

Any current medications? Please list. \_\_\_\_\_

Does this child have any severe allergies? Please explain. \_\_\_\_\_

Is a modified diet necessary? If so, please explain. \_\_\_\_\_

Important information regarding the child's vision, hearing or speech? \_\_\_\_\_

Is any condition present that might result in an emergency? \_\_\_\_\_

Please list any significant health problems or concerns or helpful information. \_\_\_\_\_

Child's primary physician \_\_\_\_\_ Phone \_\_\_\_\_

Child's dentist \_\_\_\_\_ Phone \_\_\_\_\_

Health insurance provider \_\_\_\_\_ Policy # \_\_\_\_\_

In the event of an emergency, I authorize Good Shepherd Preschool to implement emergency medical procedures as needed for the health and safety of my child.

Parent signature \_\_\_\_\_ Date \_\_\_\_\_

GOOD SHEPHERD PRESCHOOL EMERGENCY CONTACT / AUTHORIZED RELEASE FORM

Child's name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_  
Mother's name \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Father's name \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contacts - The following persons may be contacted in the event of an emergency if the parent/guardian is unreachable. A minimum of two contacts must be provided.

Name \_\_\_\_\_ Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Name \_\_\_\_\_ Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Authorized Release - The following persons are authorized to pick up the above child from preschool. Good Shepherd requires photo ID prior to releasing the child.

Name \_\_\_\_\_ Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Name \_\_\_\_\_ Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

In the case of a serious accident or medical condition, when I cannot be reached, I hereby authorize Good Shepherd Preschool to implement emergency procedures for the health and safety of my child. I understand that 911 will be called if deemed medically necessary. In the event that additional medical care is needed, I authorize medical personnel to transport my child to the following hospital:

My child's primary physician is \_\_\_\_\_ and the clinic phone number is \_\_\_\_\_.  
My child's dentist is \_\_\_\_\_ and the clinic phone number is \_\_\_\_\_.  
Important information to be provided to the medical personnel includes \_\_\_\_\_  
\_\_\_\_\_.

Health Insurance Provider \_\_\_\_\_ Policy Number \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

# Skills Evaluation

*This is merely a tool to help us plan for your child's needs. Be assured that your child is "ready" for preschool, even if he/she doesn't know any of these skills yet.*

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Assessment Date \_\_\_\_\_

Recognizes numbers circled

Recognizes colors circled

Recognizes letters circled

3 8 6 2 1  
4 5 9 7 10  
11 14 12 15 18  
13 16 17 20 19

Red Blue Yellow  
Green Purple Orange  
Black Pink Brown  
Grey White

Aa Bb Ee Gg Jj Ff  
Dd Cc Hh Ll Mm Pp  
Ii Kk Oo Ss Nn Qq  
Rr Tt Ww Zz Uu

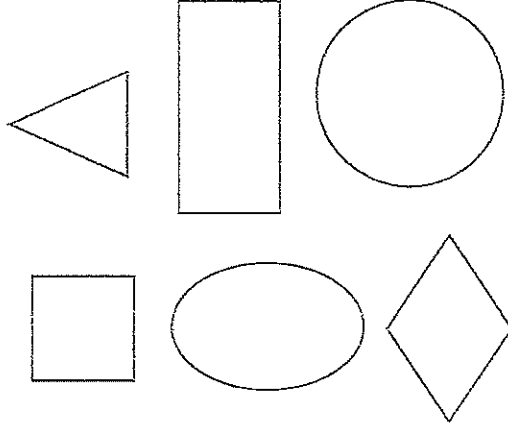
Can count by self from 1 to \_\_\_\_\_

Please check those that apply:

Recognizes shapes circled

Xx Vv Yy

\_\_\_\_ Knows full name  
(first, middle, last)  
\_\_\_\_ Recognizes first name in  
print  
\_\_\_\_ Can say or sing alphabet?  
\_\_\_\_ Can hold writing tool with  
effective grip



Which hand does your child  
typically use for writing?  
Right \_\_\_\_\_ Left \_\_\_\_\_ Both \_\_\_\_\_

If your child can already print  
some letters, show us below!

\_\_\_\_\_  
Child's Name

**To help us know you and your child better, please complete the information below.**

Important people in my child's life: \_\_\_\_\_  
\_\_\_\_\_

Pets and their names: \_\_\_\_\_

What special interests does your child have? (Favorite toys, activities, places to go, etc.)  
\_\_\_\_\_

Religious Affiliation and Church Home, if any: \_\_\_\_\_

Is your child baptized? \_\_\_\_ yes, \_\_\_\_ no

What community or church classes has your child attended, if any? \_\_\_\_\_

Please provide a brief description of your child's characteristic personality: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe any difficult or unusual behavior challenges:  
\_\_\_\_\_  
\_\_\_\_\_

Please describe child's type of home discipline: \_\_\_\_\_  
\_\_\_\_\_

Was your child born prematurely? \_\_\_\_\_

Does your child have any developmental delays of which you are aware? \_\_\_\_\_

Please list any concerns you have about your child's development: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you completed the FREE preschool screening through your local school district (which must be conducted before entering a public school Kindergarten?) \_\_\_\_ yes \_\_\_\_ no

How do you hope Good Shepherd's Preschool will benefit your child?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Supplies for Good Shepherd Preschool

We will be sharing the art supplies so no names to be on those items. But please label all personal items!

- Backpack
- Sturdy Pocket Folder - this will go back and forth from home to school each day!
- Box of 5 oz. Dixie Cups
- 4 oz. bottle of Elmer's Washable School Glue
- Elmer's Purple Glue Sticks
- One box Crayola Washable Markers - Broad Line
- 3-ringed Binder ( $\frac{1}{2}$ " or 1" size) to store Jesus Story Sheets at home
- Change of clothing in ziplock bag to be kept at school- label with child's name
  - (Include socks, pants, shirt and underwear)
- 4"x6" Family Photo for Display at School - may be emailed/texted to us or printed at home
- Tennis shoes - **Velcro closures are highly encouraged!**- NO open-toed sandals or slippery "dress" shoes.
- Winter Outdoor Clothing: snow pants, boots, mittens, hat
- Rain boots

## **Mrs. Streckert/Arndt's 4 yr old class only**

- Box of 24 Washable Crayola Crayons
- Spiral Notebook -labeled with name

## **Mrs.Redders' 3 yr old class only**

- 1 Box JUMBO Crayola Crayons - 8 or 16 count

## **Afternoon Students only**

- Small lightweight blanket and/or small pillow for rest time and sturdy reusable bag for weekly storage on coat hook.
- Lunchbox (and ice pack/thermos?)

Rev. 6/21