ST. MARY'S
CATHOLIC SCHOOL - MORRIS, MN

REGISTRATION FORM

p.(320)589-1704
www.stmarysmorris.com

The following information is needed for school records. All information given will be considered confidential. Please call if there is a change in any of this information at any time during the year. **PLEASE PRINT**

STUDENT INFORMATION

Student's Name _____ Sex: ☐ Male ☐ Female
Last First Middle

Grade: _____ Age: _____ Birthdate: _____ Religion: ☐ Catholic ☐ Other

Ethnicity: ☐ White ☐ Asian ☐ Black ☐ Hispanic ☐ Am. Indian

Place of Birth: _____
City County State

Home Address: _____ Home Telephone: _____
Street City State Zip

PARENT/GUARDIAN INFORMATION

Parent #1 Name: _____ Relationship: ☐ Parent ☐ Grandparent ☐ Guardian

E-Mail Address: _____ Cell Phone: _____

Place of Employment: _____ Work Phone: _____

Parent #2 Name: _____ Relationship: ☐ Parent ☐ Grandparent ☐ Guardian

E-Mail Address: _____ Cell Phone: _____

Place of Employment: _____ Work Phone: _____

Marital Status: ☐ Married ☐ Single
Student Lives With: ☐ Father ☐ Mother ☐ Both Parents ☐ Guardian

FAMILY INFORMATION

Number of children in Family: _____ Rank in family: _____

Name: _____ Age: _____ Grade: _____ St. Mary's Student? ☐ Yes ☐ No
Name: _____ Age: _____ Grade: _____ St. Mary's Student? ☐ Yes ☐ No
Name: _____ Age: _____ Grade: _____ St. Mary's Student? ☐ Yes ☐ No
Name: _____ Age: _____ Grade: _____ St. Mary's Student? ☐ Yes ☐ No

Family doctor to call in case of emergency or illness: _____ Phone: _____

Emergency Contacts:
#1: _____ Phone: _____ Address: _____
#2: _____ Phone: _____ Address: _____

Will bus transportation be required? ☐ Yes ☐ No

_____ _____ _____
Parent#1 Signature Parent #2 Signature Date

In accordance with federal law this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability.

Family and Social Background

This form will be shared with your child's teacher.

Members of household and their relationship to child:

_____

_____

Marital status of Parents: ☐married ☐single parent ☐separated ☐divorced
☐other:_____

Custody or visiting arrangements: _____

If child is adopted, age of adoption_____ Does your child know about it? _____

Does this child have any allergies (including allergies to medications)? _____

Describe your child's eating habits? Is a modified diet necessary?

_____

Provide information about your child's toileting habits: _____

Has your child previously attended a childcare center or daycare? _____

How long? _____ Was it a successful placement? _____
Comments:

Please list the names and telephone numbers of any persons authorized to take the child from the center

Name: _____ Phone _____
Name: _____ Phone _____
Name: _____ Phone _____
Name: _____ Phone _____

Please list the persons to be contacted if a parent cannot be reached in an emergency or when there is an injury requiring medical attention

Name: _____ Phone _____

Address

_____

Name: _____ Phone _____

Address

_____

If your child have any emotional, behavioral, or medical concerns that we should be aware of please explain below.

Child's Schedule at the center – please check the days/times your child will be at school:

	AM 8:15am-12:30pm	PM 12:30pm-3:05pm	After-Care 3:05pm-5:45pm
Monday:	☐	☐	☐
Tuesday:	☐	☐	☐
Wednesday:	☐	☐	☐
Thursday:	☐	☐	☐
Friday:	☐	☐	☐

_____ _____

Parent/Guardian Signature Date

Non-Prescribed Medication Authorization

The following non-prescribed items: diapering products, sunscreen lotions, teething gel and insect repellants will be given with parental permission and according to manufacturer's instructions unless there are written instructions provided by a licensed physician or dentist.

The following is by Director Exception only: Child will be given prescribed or non-prescribed oral or surface medication with physician permission. Medication must be in its original container and have a legible label with the child's name and current prescription information. Non-prescribed items (cold medicine or Tylenol) not mentioned above must be accompanied by a doctors note. The administration of medication is recorded and the record is approved by the child's parent. Any expired or unused portion will be returned to the child's parent or destroyed.

I hereby authorize the staff of St. Mary's School to administer the checked below listed medications. I understand that no other prescribed or non-prescribed medications will be given without physician's written permission.

_____ Teething Gel (oral gel)
_____ Sunscreen Lotions
_____ Diapering Products
_____ Insect Spray

_____

Signature of parent or guardian Date

Field Trip Authorization

I hereby give my permission for my child to go on impromptu walking field trips in the neighborhood. This includes walks around the blocks in the adjoining neighborhood. I understand that I will be notified of field trips for farther distances through a written permission form.

_____

Signature of parent or guardian Date

Parent Handbook and Program Plan

By signing this form you are acknowledging that you have received, read, had an opportunity to ask questions, understand, and agree to abide by our Parent Handbook and Program Plan.

_____

Signature of parent or guardian Date

Emergency Authorization

I authorize St. Mary's School to act on my behalf in the case of an emergency and provide emergency care and treatment.

_____

Signature of parent or guardian Date

Health Care Summary

Completed by a health care provider

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 School

Other information helpful to the school:

_____

_____

Child's source of regular medical care:

Name: _____ Phone _____

Address: _____

Dental Care:

Name: _____ Phone _____

Address: _____

Emergency Medical Care:

Name: _____ Phone _____

Address: _____

Emergency Dental Care:

Name: _____ Phone _____

Address: _____

Signature of Health Source _____ **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 (×)	**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 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 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 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.)

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Publicity Release

Throughout the school year, St. Mary's School will conduct activities that may be publicized through local and national news media. These activities may include interview sessions with news reporters, photographs of individual students or groups of students for newspapers or various school publications including newsletters, calendars, brochures, the use of student photos on the St. Mary's Website, Facebook, church bulletin and video taping for news programs and school promotional videos.

Please check one of the two statements below. Sign and return this document to school.

___ I grant permission for my name, our child(ren)'s name, voice and photographic likeness to be used by St. Mary's School personnel, publicists, or reporters, journalists or photographers employed by the news media.

___ I do not give permission for my name, my child(ren)'s name, voice and photographic likeness to be used by St. Mary's School personnel, publicists or reporters, journalists, or photographers employed by the news media.

Child(ren)'s Name(s): _____

Signed: _____
Parent/Guardian

Date: _____

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