La Crescent Montessori & STEM School

Minnesota Public Charter School District 4054
1116 South Oak Street
La Crescent, MN 55947
507-895-4054 (Phone) 507-895-4064 (Fax)

APPLICATION FOR SCHOOL YEAR: _____

Today's Date _____ Received Date _____

Circle the grade for that school year

Pre-K(3) Pre-K(4) K 1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th

Full name of child_____

Primary Contact(s) (Please circle all that apply: father, mother; legal guardian)

Name _____

Full Address_____

_____

Primary Phone(___)_____ Description: _____

Primary E-mail _____

Secondary Contact (Please circle all that apply: father, mother; legal guardian or other)

Name & Relationship_____

Full Address_____

_____

Primary Phone(___)_____ Description: _____

Primary E-mail _____

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ENROLLMENT FORM

Full name of child_____

Date of Birth _____ Male/Female_____

Age as of September 1st of enrolled year _____

Does student reside in La Crescent-Hokah School District? ☐ **yes** ☐ **no**
If no, in which school district does student reside? _____

Circle the grade for that school year

Pre-K(3) Pre-K(4) K 1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th

Primary Contact(s) (Please circle all that apply: father, mother; legal guardian)

Name _____

Full Address_____
_____

Primary Phone(___)_____ Description: _____
Secondary Phone (___)_____Description: _____
Primary E-mail _____
Secondary Email_____

Secondary Contact (Please circle all that apply: father, mother; legal guardian or other)

Name & Relationship_____

Full Address_____
_____

Primary Phone(___)_____ Description: _____
Secondary Phone (___)_____Description: _____
Primary E-mail _____
Secondary Email_____

EMERGENCY INFORMATION

MEDICAL MATTERS/EMERGENCY MEDICAL TREATMENT:

I hereby warrant that, to the best of my knowledge, my child is in good health and I assume all responsibility for the health of my child. In the event of an emergency, I hereby give my permission for the school staff to initiate emergency treatment and to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital doctor. In the event of any emergency, if you are unable to reach me at the above phone numbers, I give the following listed people my permission to transport my child and make medical decisions in my absence.

In the event that I cannot be reached, please contact:

Name/Relationship:_____ Daytime Phone:_____

Address_____

Name/Relationship:_____ Daytime Phone:_____

Address_____

Family Doctor:_____ Clinic:_____

Phone:_____

Family Dentist:_____ Clinic:_____

Phone:_____

Family Health Plan Carrier:_____ Policy #:_____

Phone:_____**(Include a copy of insurance card, front and back, to ensure speedy medical attention in the event of an emergency.)**

Are there any allergies to drugs or foods?_____

_____

Does the student take any special medication? (Please complete a "Medication Order Form).

_____

Are there any health concerns/conditions (ex. asthma, diabetes, vision)?_____

_____

PLEASE COMPLETE THE FOLLOWING INFORMATION IF YOUR CHILD ATTENDS DAYCARE:

Daycare Provider:_____ Phone:_____

Address:_____

The information I have provided is accurate to the best of my knowledge.

_____ _____

Date Signature of Parent/Guardian

STUDENT TRANSPORTATION PLANS

My child will arrive to school by:

- ☐ walking
- ☐ biking
- ☐ bus (include number if known)_____
- ☐ parent will drop off
- ☐ other responsible adult will drop off (include name)_____

Additional Comments:_____

My child will leave school by:

- ☐ walking
- ☐ biking
- ☐ bus (include number if known)_____
- ☐ parent will pick up
- ☐ other responsible adult will pick up (include name)_____

Additional Comments:_____

If school closes early due to bad weather, etc., do the above transportation plans remain the same for your child?

- ☐ yes
- ☐ no—this is our alternate emergency plan:_____

Persons other than parents/guardians authorized to call upon or pick up child:

Name:_____ Home Phone:_____ Work Phone:_____

Name:_____ Home Phone:_____ Work Phone:_____

Name:_____ Home Phone:_____ Work Phone:_____

REQUEST FOR STUDENT SOCIAL SECURITY NUMBER

All Minnesota school districts are part of a state-wide computer reporting system which uses the student social security number to record information about your child. This information is, in turn, provided to the Minnesota Department of Education.[1] This Department is required by law to collect and store information about each pupil, each staff member, and each educational program. Therefore, we ask that you, the parent, provide your child's social security number although you are not legally required to do so.

The Department of Education uses this information to determine how much money your school district receives from the state and federal government. This information is also used to judge the quality of the state's educational programs, to improve instruction, to follow trends in student enrollment, and to track student participation in various programs.

Your child's school district will share this information with the Department of Education. The Department of Education will share the information with the Department of Human Services to allocate additional funding and improve instruction. As a parent, you do not have to provide your child's social security number. If you choose not to provide the number, the school district staff might need to submit another type of report to receive money distributed by the state or federal government.

[1] Minnesota Statutes Sections 121.932 and 124.17

PARENTAL CONSENT STATEMENTS

*For each statement, **initial** the line next to the statement if you give consent. If you do not give consent, circle "No" and provide any comments.*

____ I give LMSS and all its staff members permission to administer Syrup of Ipecac to my child after being told to do so by the Poison Control Center.

____ No. Comment:_____

____ I give permission for the LMSS staff to give basic first aid.

____ No. Comment:_____

____ I give permission for my child to participate in walking field trips during operating hours.

____ No. Comment:_____

____ I give this written permission for my child to participate in any of the field trips, tours, and excursions taken in the current school year by LMSS. I understand that all field trips will be supervised by a staff member and/or adult chaperones.

____ No. Comment:_____

____ I give LMSS and all its staff and volunteers permission to arrange for or provide transportation for my child during field trips.

____ No. Comment:_____

____ I give LMSS permission to photograph/videotape my child (during normal activities of the day, during special events and on field trips) for display purposes, yearbook, marketing or special events. Any web photos would be without name or identification.

____ No. Comment:_____

How did you hear about La Crescent Montessori & STEM School?

☐ Radio ☐ Community Education Publication

☐ Newspaper ☐ Word of Mouth

☐ Internet ☐ Other _____

La Crescent Montessori & STEM School
1116 South Oak Street, La Crescent, MN 55947 (507) 895-4054

HEALTH CARE SUMMARY

Child's Name: _____
Birthday: _____
Address: _____
Primary Contact Name: _____
Primary Contact Telephone: _____

To be completed by health care source:
IF PARENTS/GUARDIANS FILL OUT THIS FORM, THEY TAKE FULL RESONSIBILITY TO PROVIDE COMPLETE AND TRUTHFUL INFORMATION.

1. Date of last physical examination: _____
   a. Child's physical examination shall be dated not more than six months prior to nor than three months after admission.
2. How long have you been seeing this child? _____
3. Does this child have any allergies? ☐ Yes ☐ No
   a. If yes, please describe them and indicate special preventions or care needed:

_____
_____

4. Does this child have a history of:
   - ☐ physical handicaps
   - ☐ heart problems
   - ☐ asthma
   - ☐ rheumatic fever
   - ☐ diabetes
   - ☐ seizures
   - ☐ other problems (specify) _____

_____
_____

5. Is this child on any medication? ☐ Yes ☐ No
   If yes, please list: _____

_____

6. Is a modified diet necessary? Please specify.

_____

7. Is any condition present that may result in an emergency?

_____
_____

8. What is the status of the child's:
   Vision: _____
   Hearing: _____
   Speech: _____
9. For medical reasons, this child should not receive the following immunizations:

_____

10. This child may participate in physical education, recreation or related activities without undue risk or injury. ☐ Yes ☐ No

_____ _____
Signature of Licensed Examining Physician (or parent if parent filled out form) Date

_____ _____
Address of clinic/hospital Phone

Full name of child_____
Grade _____Date of birth_____

Are there any allergies to drugs or foods?_____
_____
_____

Does the student take any special medication? (Please complete a "Medication Order Form). _____
_____

Are there any health concerns/conditions (ex. asthma, diabetes, vision)?_____
_____

Primary Contact(s) (Please circle all that apply: father, mother; legal guardian)
Name _____
Cell Phone #1 (_____)_____Cell Phone #2 (___)_____
Secondary Contact (Please circle all that apply: father, mother; legal guardian or other)
Name _____
Cell Phone #1 (_____)_____Cell Phone #2 (___)_____

Insurance Company: _____
Policy Number: _____
Preferred Hospital: _____
Preferred Doctor: _____

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Minnesota Language Survey

Minnesota is home to speakers of more than 100 different languages. The ability to speak and understand multiple languages is valued. The information you provide will be used by the school district to see if your student is multilingual. In Minnesota, students who are multilingual may qualify for a Multilingual Seal upon further assessment. Additionally, the information you provide will determine if your student should take an English proficiency test. Based upon the results of the test, your student may be entitled to English language development instruction. **Access to instruction is required by federal and state law. As a parent or guardian, you have the right to decline English Learner instruction at any time.** Every enrolling student must be provided with the Minnesota Language Survey during enrollment. Information requested on this form is important to us to be able to serve your student. Your assistance in completing the Minnesota Language Survey is greatly appreciated.

Student Information	
Student's Full Name: (Last, First, Middle)	Birthdate or Student ID:

	Check the phrase that best describes your student:	**Indicate the language(s) other than English in space provided:**
1. My student first learned:	___ language(s) other than English. ___ English and language(s) other than English. ___ only English.	
2. My student speaks:	___ language(s) other than English. ___ English and language(s) other than English. ___ only English.	
3. My student understands:	___ language(s) other than English. ___ English and language(s) other than English. ___ only English.	
4. My student has consistent interaction in:	___ language(s) other than English. ___ English and language(s) other than English. ___ only English.	

Language use alone does not identify your student as an English learner. If a language other than English is indicated, your student will be screened for English language proficiency.

Parent/ Guardian Information	
Parent/Guardian Name (printed):	
Parent/Guardian Signature:	Date:

* All data on this form is private. It will only be shared with district staff who need the information to best serve your student and for legally required reporting about home language and service eligibility to the Minnesota Department of Education. At the district and at the Minnesota Department of Education, this information will not be shared with other individuals or entities, except if they are authorized by state or federal law to access the information. Compliance with this request for information is voluntary.

Early Childhood Immunization Form

*Must be on file **before** a child attends any early childhood programs**

Name _____

Birthdate _____

Date of Enrollment _____

Minnesota law requires children enrolled in early education programs to be immunized against certain diseases or file a legal medical or conscientious exemption.

*Early childhood programs are defined as programs that provide instructional or other services to support children's learning and development and:

- Serve children from birth to kindergarten.
- Meet at least once a week for at least six weeks or more during the year.

This includes but not limited to early childhood family education (ECFE), early childhood special education (ECSE), school readiness programs, and other public and private preschool and pre-kindergarten programs.

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.

Additionally, if a parent or guardian would like to give permission to the early education program to share their child's immunization record with Minnesota's immunization information system, they may sign section 3 (optional).

For updated copies of your child's immunization 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 age 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)

Box 3 to provide consent to share immunization information (optional)

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 early childhood programs:

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.)

3. Parental/Guardian Consent to Share Immunization Information (optional):

Your child's early childhood program is asking your permission to share your child's immunization documentation with MIIC, Minnesota's immunization information system, to help better protect children from disease and allow easier access for you to retrieve your child's immunization record. You are not required to sign this consent; it is voluntary. In addition, all the information you provide is legally classified as private data and can only be released to those legally authorized to receive it under Minnesota law.

I agree to allow early childhood program personnel to share my child's immunization documentation with Minnesota's immunization information system:

_____

Signature of parent or legal guardian Date

Student Immunization Form

Student Name _____

Birthdate _____ Student Number _____

Minnesota law requires children enrolled in school to be immunized against certain diseases or file a legal medical or conscientious exemption.

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

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.

Additionally, if a parent or guardian would like to give permission to the school to share their child's immunization record with Minnesota's immunization information system, they may sign section 3 (optional).

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.

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+HepB+IPV, Hib+HepB) in each applicable space.

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, DT) • for children age 6 years and younger • final dose on or after age 4 years					5th dose not required if 4th dose was given on or after the 4th birthday
Tetanus and Diphtheria (Td) • for children age 7 years and older • 3 doses of Td required for children not up to date with DTaP, DTP, or DT series above					
Tetanus, Diphtheria and Pertussis (Tdap) • for children in 7th - 12th grade					
Polio (IPV, OPV) • final dose on or after age 4 years				4th dose not required if 3rd dose was given on or after the 4th birthday	
Measles, Mumps, and Rubella (MMR) • minimum age: on or after 1st birthday					
Hepatitis B (hep B)					
Varicella (chickenpox) • minimum age: on or after 1st birthday • vaccine or disease history required					
Meningococcal (MCV, MPSV) • for children in 7th - 12th grade • booster given at age 16 years					
Recommended					
Human Papillomavirus (HPV)					
Hepatitis A (hep A)					
Influenza (annually for children 6 months and older)					

Additional exemptions:

- **Children 7 years of age and older:** A history of 3 doses of DTaP/DTP/DT/Td/Tdap and 3 doses of polio vaccine meets the minimum requirements of the law.
- **Students in grades 7-12:** A Tdap at age 11 years or later is required for students in grades 7-12. If a child received Tdap at age 7-10 years another dose is not needed at age 11-12 years. However, if it was only a Td, a Tdap dose at age 11-12 years is required.
- **Students 11-15 years of age:** A 3rd dose of hepatitis B vaccine is not required for students who provide documentation of the alternative 2-dose schedule.
- **Students 18 years of age or older:** Do not need polio vaccine.

Student Name _____

Instructions, please complete:
Box 1 to certify the child's immunization status
Box 2 to file an exemption (medical or concientious)
Box 3 to provide consent to share immunization information (optional)

1. Certify Immunization Status. Complete A or B to indicate child's immunization status.

A. Received all required immunizations:

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

_____
Signature of Parent / Guardian OR Physician / Public Clinic

_____ Date

B. Will complete required immunizations within the next 8 months:

I certify that this student has received at least one dose of vaccine for diphtheria, tetanus, and pertussis (if age-appropriate), polio, hepatitis B, varicella, 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 on which the remaining doses are to be given are:

_____
Signature of Physician / Public Clinic

_____ Date

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

A. Medical exemption:

No student is required to receive an immunization if they have a medical contraindication, history of disease, or laboratory evidence of immunity. For a student 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 student 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 student or others they come in contact with. In a disease outbreak schools may exclude children who are not vaccinated 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

3. Parental/Guardian Consent to Share Immunization Information (optional):

Your child's school is asking your permission to share your child's immunization documentation with MIIC, Minnesota's immunization information system, to help better protect students from disease and allow easier access for you to retrieve your child's immunization record. You are not required to sign this consent; it is voluntary. In addition, all the information you provide is legally classified as private data and can only be released to those legally authorized to receive it under Minnesota law.

I agree to allow school personnel to share my student's immunization documentation with Minnesota's immunization information system:

_____
Signature of parent or legal guardian Date