



ENROLLMENT FORM

DATE OF ENROLLMENT

CHILD INFORMATION

First Name: _____ Last Name: _____
Address: _____ Grade applying for: _____
City/State/Zip: _____ Date of Birth: _____ Sex: M | F

ENROLLING PARENT/GUARDIAN INFORMATION

First Name: _____ Last Name: _____
Address: _____
City/State/Zip: _____
Home Phone: _____ Cell Phone: _____
E-mail: _____ Driver's License #: _____
Place of Employment: _____ Phone: _____

SECOND PARENT/GUARDIAN INFORMATION

First Name: _____ Last Name: _____
Address: _____
City/State/Zip: _____
Home Phone: _____ Cell Phone: _____
E-mail: _____ Driver's License #: _____
Place of Employment: _____ Phone: _____

Child Live with: Both Parents Mother Father Grandparents Other: _____

Authorization to Pick-Up Child/Emergency Contact

***Proper Notification and Identification is required before the child will be released to anyone.**

Name: _____

Relationship to Child: _____ Phone Number: _____

Name: _____

Relationship to Child: _____ Phone Number: _____

Name: _____

Relationship to Child: _____ Phone Number: _____

Please list anyone who is **NOT ALLOWED** to pick-up your child from VACA School.
(A copy of the court order is required if a parent is not allowed to pick up the child)

Names: _____

AUTHORIZED EMERGENCY CONTACTS - REQUIRED

We will contact if we are unable to reach either parent/guardians and will be authorize to pick-up the child. Please ensure the Authorized Emergency Contacts match those on your Emergency Card.

Name: _____ Phone: _____
Address: _____ Relationship: _____

MEDICAL INFORMATION

Child’s Physician/Clinic: _____ Phone Number: _____
Address: _____

Child’s Dentist: _____ Phone Number: _____
Address: _____

Does your child have any **Allergies**? Yes No Please describe if Yes: _____

Are there any **Medical** concerns or needs concerning your child that we should be aware of? Yes No
Please describe if Yes: _____

RELEASE AGREEMENT

- _____ 1. I have received a copy of the Tuition fees and will agree to the rates for the school year.
- _____ 2. I have received a copy of the Parent Handbook. I know it is my responsibility to read it.
- _____ 3. I authorize Verndale Area Christian Academy staff to initiate emergency medical and dental care (i.e. CPR/First Aid) and to call Emergency Personnel (911), if need arises.
- _____ 4. I authorize Verndale Area Christian Academy staff to contact Poison Control, if need arises, and follow any guidelines they recommend for my child.
- _____ 5. I hereby give permission for Verndale Area Christian Academy my enrolled child in to have photos taken and printed in newspapers, newsletters, school website for purposes of publicizing the program, reports on program progress, and sharing special events with the public. I understand that this could include videotaping.
- _____ 6. I hereby give permission for the exchange of any information between Verndale Area Christian Academy and Verndale School district staff whenever such exchange would enable either party to better meet the needs of my child.
- _____ 7. I authorize Verndale Area Christian Academy staff to take my child on walks as weather permits. Also, upon notification and my signature of permission, the center is authorized to take my child on planned filed trips on foot or appropriate transportation. I also understand that no refunds will be given unless the field trip is canceled by Verndale Area Christian Academy.

Verndale Area Christian Academy will not be responsible for anything that may happen because of false information given as part of the enrollment process.

Parent Signature: _____ Date: _____

OFFICE USE ONLY

Registration Fee Received on: ____/____/____ Rec’d by: _____ Check #: _____

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.

Vaccine	Birth to 6 months	12 -24 months	At Kindergarten	At 7th grade	At 12th grade
Hepatitis B	<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"/>
<i>Haemophilus influenzae</i> type b (Hib)	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Pneumococcal (PCV)	<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"/>
Measles, Mumps, Rubella (MMR)		<input type="text"/>		<input type="text"/>	<input type="text"/>
Chickenpox (varicella)		<input type="text"/>		<input type="text"/>	<input type="text"/>
Hepatitis A		<input type="text"/>	<input type="text"/>		
Tetanus, Diphtheria, Pertussis (Tdap)				<input type="text"/>	
Meningococcal (MCV4)				<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.

Instructions: Complete section 1 to document a medical or non-medical exemption, section 2 to verify history of varicella disease, and section 3 to consent to share immunization information.

Name _____

1. Document a medical and/or non-medical exemption (A and/or B).

Place an X in the box to indicate a medical or non-medical exemption. If there are exemptions to more than one vaccine, mark each vaccine with an X.

Vaccine	Medical Exemption	Non-Medical Exemption
Diphtheria, Tetanus, and Pertussis		
Polio		
Measles, Mumps, Rubella		
<i>Haemophilus influenzae</i> type b		
Chickenpox (varicella)		
Pneumococcal		
Hepatitis A		
Hepatitis B		
Meningococcal		

A. Medical exemption: By my signature below, I confirm that this child should not receive the vaccines marked with an X in the table for medical reasons (contraindications) or because there is laboratory confirmation that they are already immune.

Signature: _____ Date: _____
(of health care practitioner*)

2. History of chickenpox (varicella) disease. This child had chickenpox in the month and year _____

My signature below means that I confirm that this child does not need chickenpox vaccine because:

- I am a health care practitioner and this child was previously diagnosed with chickenpox or the parent provided a description that indicates this child had chickenpox in the past.
- I am the parent or guardian and this child had chickenpox on or before September 1, 2010.

Signature: _____ Date: _____
(of health care practitioner*, representative of a public clinic, or parent/guardian). Parent can sign if chickenpox occurred before September 2010.

*Health care practitioner is defined as a licensed physician, nurse practitioner, or physician assistant.

B. Non-medical exemption: A child is not required to have an immunization that is against their parent or guardian's beliefs. However, choosing not to vaccinate may put the health or life of your child or others they come in contact with at risk. Unvaccinated children who are exposed to a vaccine-preventable disease may be required to stay home from child care, school, and other activities in order to protect them and others.

By my signature, I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs. I am aware that my child may be required to stay home from child care, school, and other activities if exposed.

Signature: _____ Date: _____
(of parent or guardian in presence of notary)

Non-medical exemptions must also be signed and stamped by a notary:

This document was acknowledged before me on _____ (date) by _____ (name of parent or guardian)

Notary Signature: _____

Notary Stamp

STATE OF MINNESOTA, COUNTY OF _____

3. Consent to share immunization information: This school is asking for permission to share your child's immunization record with Minnesota's immunization information system. Giving your permission will:

- Provide easier access for you and your school to check immunization records, such as at school entry each year.
- Support your school in helping to protect students by knowing who may be vulnerable to disease based on their immunization record. This can be important during a disease outbreak.

Under Minnesota law, all the information you provide is private and can only be released to those authorized to receive it. Signing this section of the form is optional. If you choose not to sign, it will not affect the health or educational services your child receives.

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

Signature: _____ Date: _____
(of parent/guardian)