



409 First Street North
 Virginia, MN 55792
 218-741-7441
 appletreelc@gmail.com
 www.appletreelc.org

Child Information

Last Name: _____
 First Name: _____
 Date of Birth: _____ M / F
 Application Date: _____ App Fee: _____
 Wait Date: _____ Enrollment Date: _____

Primary Contact

Name Last: _____ First: _____ Email: _____
 Relationship: _____ Address: _____ City: _____ Zip: _____
 PHONE: Primary: _____ Secondary: _____
 Work Place: _____ Work Phone: _____ Ext: _____

Secondary Contact

Name Last: _____ First: _____ Email: _____
 Relationship: _____ Address: _____ City: _____ Zip: _____
 PHONE: Primary: _____ Secondary: _____
 Work Place: _____ Work Phone: _____ Ext: _____

*** **Emergency contacts** if we are unable to reach the above contacts ***

These people assume responsibility in a medical emergency AND are authorized to pick up the child in a non-emergency situation.

Emergency Contact (Different from all previous contacts)

Name Last: _____ First: _____
 Relationship: _____ Address: _____ City: _____ Zip: _____
 PHONE: Primary: _____ Secondary: _____
 Work Place: _____ Work Phone: _____ Ext: _____

Emergency Contact (Different from all previous contacts)

Name Last: _____ First: _____
 Relationship: _____ Address: _____ City: _____ Zip: _____
 PHONE: Primary: _____ Secondary: _____
 Work Place: _____ Work Phone: _____ Ext: _____

Primary Medical: Name: _____ Address: _____ Phone: _____

Emergency Medical

Name: _____ Address: _____ Primary Phone: _____

Dental Contact: Name: _____ Address: _____ Phone: _____

Emergency Dental

Name: _____ Address: _____ Primary Phone: _____

Medical Authorization: If a primary or secondary contact cannot be reached or is delayed in arriving in a medical emergency, I authorize Apple Tree's nearest source of emergency medical care to treat my child.

Authorized Signature _____ Date _____

Medical Information needed by emergency personnel (include allergies and identifying marks):

Agreement: I understand that it is my responsibility to keep this form current. Apple Tree is not liable if any of the information on this form is inaccurate or outdated. I will notify Apple Tree in writing of any changes in the information I have provided.

Signature: _____ Date: _____



Child's Last Name: _____
Child's First Name: _____

Additional Authorized Pick-up Persons

These names are different from the four on the front

Your Child will be allowed to leave with only people on the pick-up/contact list.

(These people must have an ID number to enter the center and present a picture ID at the time of pick up.)

Do not repeat contacts from previous page.

First Name: _____ Last Name: _____

Relationship: _____

PHONE: _____ (W/H/C) _____ (W/H/C)

First Name: _____ Last Name: _____

Relationship: _____

PHONE: _____ (W/H/C) _____ (W/H/C)

First Name: _____ Last Name: _____

Relationship: _____

PHONE: _____ (W/H/C) _____ (W/H/C)

First Name: _____ Last Name: _____

Relationship: _____

PHONE: _____ (W/H/C) _____ (W/H/C)

How did you hear about Apple Tree?

- Newspaper
- Radio
- Television
- A friend
- A family member
- Website
- Other: _____



Iron Range Learning & Development

409 1st Street North
Virginia, MN 55792
Phone (218) 741-7441
appletreelc@gmail.com
www.appletreelc.org

Last Name: _____
First Name: _____
Application Date: _____
Enrollment Date: _____

FAMILY AGREEMENT

The submission of these forms and a \$25.00 application fee is not a guarantee of enrollment. (It will start the process to get your family on our waiting list, if applicable.)

I have read the information in the application packet and the accompanying family handbook. I understand and will abide by the responsibilities set forth for families. I have completed all forms and I have provided factual information. I further understand that I am responsible for all fees and rates incurred as defined in the family handbook.

I understand that when I sign this agreement, Apple Tree will adhere to state and federal licensing requirements; fire, health and safety standards; and will provide a quality child care program to best suit my child's needs.

Failure to supply schedules and payments by established deadlines may result in interruption of services rendered for the following time period.

FAMILY SIGNATURE _____ DATE _____

DIRECTOR'S SIGNATURE _____ DATE _____

PHOTOGRAPH RELEASE

Local media including newspapers and television stations occasionally do feature stories on our center and our activities. Photos and videos may be taken for these purposes as well as for our bulletin boards, scrapbooks, community presentations, and our website/internet media (face book). All photos posted or released for public viewing do not include names or other identifying information.

I agree to allow my child's photo to be released as indicated above.

FAMILY SIGNATURE _____ DATE _____

FIELD TRIP PERMISSION

An important part of our curriculum includes walks in the neighborhood and field trips into the community. These are excellent means of expanding children's knowledge of the world around them. Regular walks include: daily trips (weather permitting) around the lake or to Chestnut Street as well as weekly trips to the Virginia Public Library (for preschool). Children are well supervised on excursions by staff and volunteers. Other field trips to specific places will require special permission.

I give my permission for my child to go on walks that are part of the curriculum at Apple Tree.

FAMILY SIGNATURE _____ DATE _____

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. (Not all prohibited bases apply to all programs.)



Child Profile Form

Child's Name _____

Date of Birth _____ Gender: _____

Anticipated Schedule: Monday Tuesday Wednesday Thursday Friday

_____ to _____ to _____ to _____ to _____

Name you wish your child to be called (nick names):

Adults and children living in child's home (names, ages, relationships):

Briefly describe your child's characteristic social/emotional behavior:

Fears (history of and how child shows fears):

Types of effective discipline/redirection most frequently used in the home:

Previous group experiences:

Napping habits and needs:

What you want for your child from this childcare experience:

Food likes and dislikes:

Eating habits and dietary restrictions*:

Any identifying marks or physical or health problems to be watched*:

Diapering/Toileting procedures*:

If child is an infant, amount of water usually given by parent:

If the child is under one year of age, amount of formula/milk and solid foods (including vitamin or iron supplements) and feeding schedule*:

Does your child have an IEP, IFP, 504 or other similar education plan? (Please provide a copy)*

***Additional forms may be needed**

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 understand 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)

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

<u>Important Health Problems</u>	<u>Followed By You</u>	<u>Followed By Other Med Source (Name)</u>	<u>Requires Special Attention at Center</u>
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Other information helpful to the child care program _____

Phone _____

Signature of Health Source _____ Address _____

Date _____