WOODDALE ACADEMY

5532 Wooddale Avenue South, Edina, MN 55424
P: (952) 656-1055

WOODDALE ACADEMY, EDINA
CHILD "EMERGENCY" INFORMATION

CHILD'S NAME _____ BIRTH DATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PREFERRED PHONE _____ PREFERRED EMAIL _____

INSURANCE INFORMATION: DO NOT HAVE HEALTH INSURANCE: ☐ Yes ☐ No

HEALTH INSURANCE POLICY NAME _____ I.D. # _____ GROUP # _____

PRIMARY SUBSCRIBER'S NAME _____ EMPLOYER _____

MOTHER _____ HOME PHONE _____ CELL PHONE _____

OCCUPATION _____ EMPLOYER _____ WORK PHONE _____

PREFERRED EMAIL _____

FATHER _____ HOME PHONE _____ CELL PHONE _____

OCCUPATION _____ EMPLOYER _____ WORK PHONE _____

PREFERRED EMAIL _____

EMERGENCY CONTACTS: THE FOLLOWING PEOPLE ARE AUTHORIZED TO BE CONTACTED IN CASE OF EMERGENCY. THESE INDIVIDUALS HAVE ACCESS TO HEALTH INFORMATION ABOUT MY CHILD & ARE AUTHORIZED TO MAKE DECISIONS IN MY ABSENCE.

EMERGENCY CONTACT #1: _____ ADDRESS _____

PHONE: _____ HOME _____ CELL _____ WORK

EMERGENCY CONTACT #2: _____ ADDRESS _____

PHONE: _____ HOME _____ CELL _____ WORK

IMMUNIZATIONS: DATE OF LAST DOSE: -_____ DTAP _____ HIB _____ IPV _____ MMR _____ CHICKEN POX

MEDICAL HISTORY: PLEASE LIST FACTS CONCERNING YOUR CHILD'S MEDICAL HISTORY INCLUDING **ASTHMA**, **ALLERGIES**, **CHRONIC ILLNESS**; **MEDICATIONS** , OR ANY **PHYSICAL IMPAIRMENTS** WHICH MEDICAL PERSONNEL SHOULD BE AWARE:

_____

_____

PLEASE COMPLETE REVERSE SIDE

CHILD'S DENTIST _____ ADDRESS _____

CLINIC PHONE _____

CHILD'S PHYSICIAN _____ ADDRESS _____

CLINIC PHONE _____ HOSPITAL PREFERENCE _____

CONSENT FOR EMERGENCY TREATMENT: I GRANT MY AUTHORIZATION AND CONSENT FOR WOODDALE ACADEMY STAFF to view my child's health information on file and administer general first aid treatment for any minor injuries or illnesses experienced by the minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize Wooddale Academy Staff to summon any and all professional emergency personnel to attend, transport, and treat the and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state of MN. It is understood that this authorization is given in advance of any such medical treatment to provide authority and power on the part Wooddale Academy Staff to exercise their best judgment upon the advice of any such medical or emergency personnel. I understand I am financially responsible for all expenses incurred to provide emergency treatment for my child.

Below are people authorized to pick up my child from Wooddale Academy

Name_____ Address_____ Phone_____

Name_____ Address_____ Phone_____

Name_____ Address_____ Phone_____

SIGNATURE OF "LEGAL" PARENT OR GUARDIAN: _____ DATE _____

PLEASE INITIAL IF INFORMATION BEEN UPDATED: _____ AUG _____ NOV _____ FEB _____ MAY

A NEW EMERGENCY FORM MUST BE COMPLETED EACH SCHOOL YEAR

PLEASE RETURN FORM TO:

WOODDALE ACADEMY, EDINA

EMAIL: EDINA.ACADEMY@WOODDALE.ORG

FAX: 952-777-4211

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WOODDALE ACADEMY, EDINA
HEALTH CARE SUMMARY
MUST BE COMPLETED BY HEALTH CARE SOURCE

NAME OF CHILD_____ AGE: _____ BIRTH DATE_____

ADDRESS_____ TELEPHONE_____

LEGAL PARENT(S) OR GUARDIAN_____

Date of last Physical Examination_____ How long have you been seeing this child?_____

MEDICAL HISTORY: **Is any condition present that might result in an emergency?** ___YES ___NO

Explain: _____

Does this child require follow-up for screening tests with abnormal test results? ___YES ___NO

Explain: _____

HEALTH CONDITIONS: Does this child have any of the following? If yes, **please attach special instructions.**

___YES ___NO **Allergy to any Medications: _____
___YES ___NO **Food Allergies: _____
___YES ___NO **Environmental Allergies: _____
___YES ___NO **Special Feeding Needs/Modified Diet: _____
___YES ___NO **Asthma
___YES ___NO **Seizures
___YES ___NO **Diabetes
___YES ___NO **Special Health Needs: _____
___YES ___NO Neuromuscular Condition: _____
___YES ___NO On-Going Health Issue that requires follow-up by you: _____
___YES ___NO Under Immunized Because of a Medical Condition: _____
___YES ___NO Hearing Impairment
___YES ___NO Vision Impairment
___YES ___NO Speech Impairment
___YES ___NO High levels of Lead
___YES ___NO Food Sensitivity

****Physician MUST attach Care Plans for these conditions as well as Medication Administration.**

IMMUNIZATIONS: **Child's immunizations are up-to-date (documented & attached):** ___ YES ___ NO
If not up-to-date, please attach a plan to bring the child's immunizations current.
Child not immunized for religious reasons. ___ YES ___ NO

Other information helpful to the Child Care Program_____

_____

Signature of Physician _____ Clinic:_____

Phone:_____ 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 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 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 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.)

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Developmental History Form
Wooddale Academy, Edina

Child's Name:_____ **Birth Date:** _____

Today's Date:_____ **Gender:** __ Male __ Female **Child's Age in Months:** _____

Parents are: ___ Married ___ Living Together ___ Divorced ___ Separated ___ Not Together

Child lives with: ___ Parents ___ Mother ___ Father ___ Other (Who?) _____

Names and ages of siblings:

_____ Age___ _____ Age___

_____ Age___ _____ Age___

_____ Age___ _____ Age___

Has your child been in preschool before? ___Yes ___No

Does your child have special feeding needs? _____
*** Wooddale Academy requires food allergies to be documented by a physician and requires a Health Care Plan on file.*

What is your child's eating patterns? _____

Does your child have special medical needs? _____
*** Wooddale Academy requires medical needs to be documented by a physician and requires a Health Care Plan on file.*

Are bowel movements regular? ___Yes ___No Usual Time(s): _____

Is diarrhea, constipation a problem? ___Yes ___No Explain: _____

What time does child go to bed at night? _____

When is the child ready for sleep? _____

Does the child take naps? ___Yes ___ No From when: _____ To when: _____

By nature is the child? ___ Friendly ___ Aggressive ___ Shy ___ Withdrawn ___ Other: _____

How does the child get along with their siblings and other adults? _____

_____

_____

PLEASE COMPLETE REVERSE SIDE

Does the child know any children at Wooddale Academy? ___Yes ___No

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

How does the child relate to strangers? _____

What makes your child happy? _____

What makes the child upset? _____

How does the child show these feelings? _____

What frightens your child? ___ Animals ___ People ___ Rough Children ___ Loud Noises
___ Darkness ___ Other Children ___ Storms

Other: _____

Favorite toys and activities at home? _____

Does the child like to be read to? ___Yes ___No **Listen to Music?** ___Yes ___No **Play outside?** ___Yes ___No

Please help us understand your family better...

What is the dominate language spoken at home? ___English Other: _____

Is there another language spoken in your home? ___Yes ___No Specify language(s): _____

How can Wooddale Academy support your linguistic expectations? _____

Describe your family support system: _____

_____

What are your preferred child rearing practices? _____

_____

What should we know about your cultural expectations: _____

_____

Please Return Form to:
Wooddale Academy, Edina
Email: Edina.Academy@Wooddale.org
Fax: 952-777-4211

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Family Data Form
Wooddale Academy, Edina

Child's Name: _____
First Middle Last

Address: _____
Street City Zip

Date of Birth: ____/____/____ Gender: _____Male _____Girl

Home Phone: _____ Father's Cell: _____

Preferred Email: _____ Mother's Cell: _____

Alternate emergency contacts when parents cannot be reached:

Name: _____ Address: _____

Phone: _____ Relationship: _____

Name: _____ Address: _____

Phone: _____ Relationship: _____

Physician: _____ Address: _____

Phone: _____

Dentist: _____ Address: _____

Phone: _____

Source of emergency care: _____
Hospital

Does child have any disability that we must be aware of? _____

Other health/adjustment information the teacher should be aware of? _____

_____

*****PLEASE COMPLETE REVERSE SIDE*****

Child lives with: _____ Both parents _____ Father _____ Mother _____Other

If Other, please specify: _____

Church Preference: _____

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Father's Name: (or guardian) Mother's Name: (or guardian)

_____ _____

Occupation: _____ _____

Employer: _____ _____

Business phone: _____ _____

==========

Siblings:	Birthdate:	Gender:	Grade:

Names and phone numbers of people authorized to pick up child from Wooddale Academy:

_____

Names of people **NOT** authorized to pick up child from Wooddale Academy:

_____

Emergency Pick–Up

If we cannot reach you, the people below will assume responsibility and are authorized to pick-up your child at the end of the day or in a medical emergency. They have access to my child's health and family history. Under NO circumstances will a child be released to anyone onto known to center staff without prior written authorization and phone identification. I understand that in the event I do not pick up my child by one hour after closing/departure time, Child Protection will be called and my child(ren) will be taken into protective custodial.

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell: _____ Work: _____

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell: _____ Work: _____

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell: _____ Work: _____

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General Permission Form
Wooddale Academy Edina

I hereby grant permission for my child _____to use all of the play equipment and participate in all activities of Wooddale Academy (on and off-site).

I hereby grant permission for my child to be included in evaluations, pictures and video connected with Wooddale Church and the Academy: Yes _____ No _____ (please initial)

I hereby grant permission to allow my child's classroom teachers to share my child's contact information with the classroom families for general purposes (play dates, birthday activities, etc.): Yes _____ No _____ (please initial)

I hereby grant permission for **hand sanitizer** to be applied to my child: Yes _____ No _____ (please initial)

I hereby grant permission for **sunscreen** to be applied to my child: Yes _____ No _____ (please initial)

I hereby grant permission for the Director or Professional Staff to take whatever steps may be necessary to obtain emergency medical care for my child if warranted. I give Wooddale Academy Staff permission to access my child's file, to post food allergy/medical information regarding my child's health within the facility as a visual reminder to staff. In the case of an emergency, the following steps (which may include, but are not limited to) will be followed:

1. **Attempt to contact legal parent or guardian.**
2. **Attempt to contact the child's physician.**
3. **Attempt to contact you through any of the persons listed on the Family Data Sheet/Emergency Information Form** you completed for us. If you cannot be reached, the people you listed on these forms will be notified as to the emergency and asked to respond in your absence. These people may be asked to make decisions regarding your child's emergency care in your absence.
4. **If we cannot reach you, your child's Physician or Emergency contacts listed by you,** we will do any–OR–all of the following:
    a. Call another Physician or the Paramedics.
    b. Call an Ambulance.
    c. Have the child taken to the Emergency Room (nearest hospital) in the company of a staff member.
5. **<u>Any expenses</u> incurred under #4 above, will be the legal parent/guardian's responsibility.**
6. **Wooddale Academy will not be responsible** for the consequences associated with inaccurate information provided by parent at the time of enrollment.
7. **Wooddale Academy will not assume responsibility/liability** for a child who has **not been checked in** when the child arrives for the day.

Signature of child's ***"legal" Parent or Guardian***:

_____ Date: _____

****Note: If parents are divorced, Wooddale Academy requires PROOF (copy of Official Court Order) of legal custodial parent.**

Printed Name of **"legal" Parent or Guardian**:

_____

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Wooddale Academy, Edina
Media Permission Form

I hereby give the Wooddale Academy and Wooddale Church permission to use photographs, video of my child OR family in the following ways:

Display photos or video ***of my child***:

☐ Yes ☐ No **Inside the Academy**

☐ Yes ☐ No On the **Academy's Website**

☐ Yes ☐ No Posted on the **Academy's Facebook Page**

☐ Yes ☐ No In **Wooddale Church's** publications or Website

Display photos or video ***of my family***:

☐ Yes ☐ No **Inside the Academy**

☐ Yes ☐ No On the **Academy's website**

☐ Yes ☐ No Posted on the **Academy's Facebook Page**

☐ Yes ☐ No In **Wooddale Church's** publications or Website

Child(ren) Name(s):

_____

Teacher(s):

_____

Parent/Guardian Signature:

_____

Date: _____

Tuition™ Express

Automated Payment processing
Safe - Convenient - Easy

We are excited to offer the safety, convenience and ease of Tuition Express™ – an automatic payment processing system that allows on-time tuition and fee payments to be made from your bank account.

AUTHORIZATION FOR BANK ACCOUNT ELECTRONIC FUNDS TRANSFER

I (we) hereby authorize **Wooddale Academy** (business name) to initiate debit entries to my (our) Checking or Savings Account indicated below. To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice.

Credit Union Members: Please contact your Credit Union to verify account and routing numbers for automatic payments.

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____

Bank or Credit Union Address _____ City _____ State _____ Zip _____

☐ Checking ☐ Savings

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____

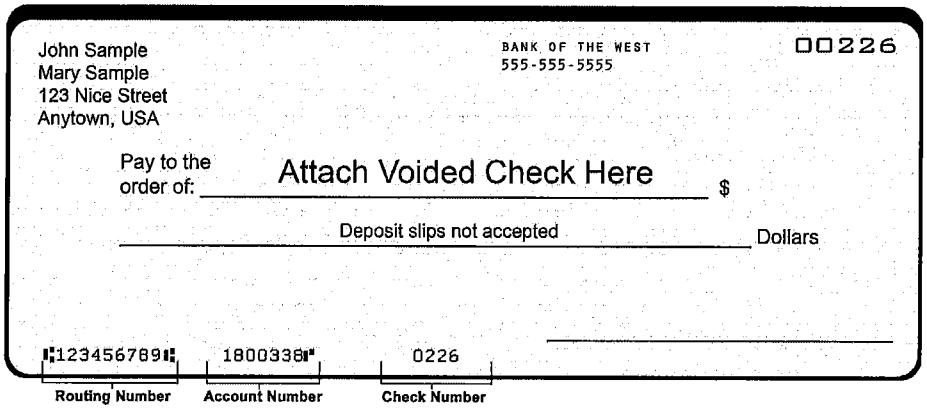
Signature _____ Date _____

☐ Check if you wish to make online payments

For Official Use Only...

Date Received _____

Employee Signature _____



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Tuition™ Express

Automated Payment processing
Safe - Convenient - Easy

We are excited to offer the safety, convenience and ease of Tuition Express™ – an automatic payment processing system that allows on-time tuition and fee payments to be made from your bank account.

AUTHORIZATION FOR CREDIT CARD

I (we) hereby authorize **Wooddale Academy** (business name) to initiate recurring credit card charges to the below referenced credit card account. To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice.

Please contact Center Representative for a list of Credit Cards Accepted as Payment.

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

XXXX-XXXX-XXXX-__ __ __ __

Credit Card Number (Last 4 Digits ONLY) _____ Expiration Date _____

Signature _____ Today's Date _____

☐ Check if you wish to make online payments

A service of

procare SOFTWARE®

For Official Use Only...

_____
Date Received

_____
Employee Signature

- < Cut Here > -

FULL Credit Card Number _____ Expiration Date _____

Today's Date _____

For Security, please...

☐ return this Section of the Authorization Form.

☐ Shred this Section of the Authorization Form.