Wooddale Academy

Inspiring Young Minds through Faith, Knowledge, and Character

EDEN PRAIRIE PARENT PACKET

Included in the Parent Packet are all the required forms to complete your child's enrollment registration at Wooddale Academy. Please return via email: academy@wooddale.org or fax: 952-777-4211.

ENROLLMENT FORMS

CHECKLIST

- ☐ **Tuition Express Bank Form**
- ☐ **Tuition Express Credit Card Form**
- ☐ **Child Emergency Form**
- ☐ **Health Care Summary Form**
  MUST BE COMPLETED BY HEALTH CARE SOURCE
- ☐ **Immunization Form**
- ☐ **Non-Prescription Medication Form**
- ☐ **Developmental History Form**
- ☐ **Family Data Form**
- ☐ **General Permission Form**
- ☐ **Media Permission Form**
- ☐ **Getting to Know You Form**

Greetings Families,

On behalf of our entire staff, I would like to welcome you to Wooddale Academy.

What an exciting time whether you are new to Wooddale Academy or you are a returning family!

I am thrilled you have chosen to be part of the WA family and we look forward to partnering together while your child attends our program.

Melissa Brown-Pinard
Executive Director

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 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) _____

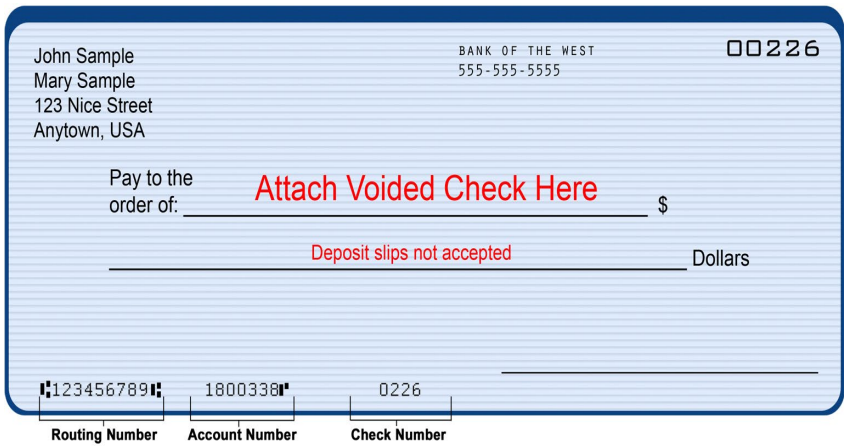
Signature _____ Date _____

☐ Check if you wish to make online payments

For Official Use Only...

_____
Date Received

_____
Employee Signature



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AUTHORIZATION FOR CREDIT CARD

I (we) hereby authorize Wooddale Academy 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 _____

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For Official Use Only...

_____
Date Received

_____
Employee Signature

- < Cut Here > -

FULL Credit Card Number _____ Expiration Date _____

For Security, please...
- ☐ return this Section of the Authorization Form.
- ☐ Shred this Section of the Authorization Form.

Today's Date _____

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e: academy@wooddale.org

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

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Email: academy@wooddale.org
Fax: 952.777.4211

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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 _____

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								
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)								
Haemophilus influenzae type b (Hib)								
Pneumococcal (PCV)								
Polio								
Measles, Mumps, Rubella (MMR)								
Chickenpox (varicella)								
Hepatitis A								
Tetanus, Diphtheria, Pertussis (Tdap)								
Meningococcal (MCV4)								

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:

1. 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.
2. 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.

DEPARTMENT OF HEALTH
Immunization Program (2019)
www.health.state.mn.us/immunize

Non-Prescription Medication Products Authorization Only

FORM M-400

All over-the counter (OTC) products need parental permission for administration. However, some of these external products do not need to be documented every time you use them. The following is a list requiring parental permission only.

TO BE COMPLETED BY PARENT

Child's Name: _____ Date of Birth: _____ / _____ / _____
Program Name: _____ Today's Date: _____ / _____ / _____

The following external products may be applied to my child in accordance with the manufacturer's instructions on the original container:

_____ Diaper Wipes
_____ Diaper Creams, Ointments
_____ Skin Lotions / Creams / Vaseline: Specify if Special Brand: _____
_____ Baby oil; (baby powder is not recommended due to inhalation hazards)
_____ Soap, Brand Name: _____
_____ Sunscreen: Specify if Special Brand: _____
_____ Insect Repellants: Specify if Special Brand: _____
_____ Lip Balm
_____ Chemical Hand Sanitizers
_____ Toothpaste (an internal product but does fall under this category)
_____ Other – Please Specify: _____

NOTE: Teething gels are considered OTC medications not products (use **Form M-200**) Teething gels are not recommended and need to be used with extreme caution. They have been known to numb the throat which causes a potential choking hazard.

Parents/Guardian's signature required: _____

* Unused products: Returned to parents? Yes / No **or**, discarded appropriately (circle one)

By: _____ Date: ____/____/____

***Keep this form in the child's file when medication is finished.**

All oral OTC medications need Prescription (Form M-200) or Non-Prescription (Form M-300) Medication Authorization/Administration Form completed.

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Developmental History Form

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: _____

_____

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Family Data Form

School Year: _____

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: _____

==========

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

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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Media Permission Form

I hereby give 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: _____

Wooddale Academy

"Getting to Know You"

CHILD'S FIRST NAME:	**LAST NAME:**
1. Does your child have a nickname you would prefer your child's teacher to use at school?	
2. What is your child's favorite activity?	
3. Does your child have any fears/frustrations?	
4. What is the primary language spoken in your home?	
5. What 'bathroom-terminology' does your child use? (complete if applicable)	
6. How do you handle discipline in your home?	
7. Has your child participated in a group setting without a parent? Do you anticipate any separation anxiety? How do you approach this?	
8. As a parent, what are your goals and objectives for your child this year?	
9. What concerns do you have for your child? (i.e. Allergies, Special Needs)	
10. Are you anticipating any changes/transitions in your family during the school year?	
11. Describe your child in 3 words:	