Kingdom Kids Learning Center
Child Information

(Please fill out completely and clearly in ink)

Name of Child _____ Date filling out form_____
(Last) (First)

Address_____ Phone_____
City State Zip

Date of Birth_____ Start Date _____ Drop off time_____ Pick up time _____

Days Attending Monday _____ Tuesday _____ Wednesday ____ Thursday _____ Friday _____

Father or Guardian_____ Employer_____

Address (if different from child)_____

How can you be reached when your child is in child care? _____

Cell Phone_____ Email Address: _____

Mother or Guardian_____ Employer_____

Address (if different from child)_____

How can you be reached when your child is in child care? _____

Cell Phone_____ Email Address: _____

What is the first number to call if we need to reach you _____

What is the best email for your family to receive information from child care _____

~~~~~~

Medical Insurance Co._____ Policy/Certificate #_____

Policy Holders Name: _____

~~~~~~

We are required to have an additional 2 people who can be called in an EMERGENCY and who are authorized to pick your child if you (parent/guardian) are unable to be reached. (Try to include someone who will usually know where you are and how to get a hold of you.)

Name: _____ Relation to Child: _____

Address: _____ Phone: _____

Name: _____ Relation to Child: _____

Address: _____ Phone: _____

~~~~~~

Names and phone numbers of additional persons authorized to pick up my child:

Name:_____Phone:_____Name:_____

_____Phone:_____

Name:_____Phone:_____Name:_____

_____Phone:_____

~~~~~~

Child's Physician (required) _____ Phone_____

Physician's _____
Address City State Zip

Child's Dentist (required) _____ Phone_____

Dentist's Address_____
Address City State Zip

Family Information

Please give names and relationships of others living in the home with your child

_____

_____

_____

Do you attend a church in our community? _____ Yes _____ No

If yes, which church _____

Is there an Order of Protection or child custody document involving you child (Kingdom Kids must have a copy to enforce)? _____

General Questions: (If "Yes" explain below)

	Yes	No
Has food allergies?	___	___
Must have a gluten free diet?	___	___
Must have a dairy free diet?	___	___
Has environmental allergies?	___	___
Has a heart condition?	___	___
Is subject to fainting?	___	___
Is subject to upset stomach?	___	___
Is subject to motion sickness?	___	___
Has allergic reaction to bee sting?	___	___
Has allergic reaction to any medications?	___	___
Has any other allergies?	___	___
Has glasses or vision conditions?	___	___
Has had a recent injury or illness?	___	___
Has a chronic or recurring illness?	___	___
Has ever had a seizure?	___	___
Has had chest pains?	___	___
Has diabetes?	___	___
Has asthma?	___	___
Has bleeding tendencies?	___	___
Has ever had frequent ear infections?	___	___
Has PE tubes?	___	___
Has hearing impairments?	___	___
Has frequent headaches?	___	___
Has had high blood pressure?	___	___
Has activity restrictions or limitations?	___	___
Has other ongoing health problems?	___	___
Has any mental Health concerns?	___	___
Has any behavior concerns?	___	___
Receives any medication?	___	___
Being treated by a physician or dentist?	___	___

General Questions Explained _____

_____

Does your child have any condition(s) that may get in the way of the child's everyday activities or require care that cannot be provided in staff to child ratios (1 to 4 in infants, 1 to 7 in toddlers, 1 to 10 in preschool)?

_____

_____

Is your child on a School District IEP? _____

If yes are there any adaptations needed for him/her to be successful? _____

_____

If your child has need of medication during school, food allergies, seizures, eczema / dermatitis, is allergic to bee stings or has other medical issues, please speak to the child care director and your child's teacher to obtain a written action plan form.

Important – The health information is correct as of the date the agreement is signed.

Authorization for Treatment: I understand that attempts will be made to contact parents and emergency contacts first. However if these individuals are not able to be present, I authorize Kingdom Kids Staff to administer first aid as deemed necessary as well as authorize the medical personnel selected by the staff to provide emergency medical care by medical staff to hospitalize, secure treatment for, order injection, anesthesia, blood transfusions, or surgery, and to release any records necessary for insurance purposes as well as provide or arrange necessary related transportation for the above named student. I also agree that any expenses incurred from the emergency (including any medical bills) will be borne by the child's family. Furthermore, I understand that the school will not be responsible for anything that may happen resulting from false information given at the time of enrollment or on subsequent forms. This form may be photocopied.

***SIGNATURE OF PARENT/LEGAL GUARDIAN**: _____

DATE: _____

Permission Form

Child's Name _____ Class _____

Please read and initial each item below.

_____ 1. I give permission, in the event of a medical/dental emergency when no contact person can be reached, for my child to be transported by ambulance to the nearest appropriate facility for receiving medical/dental care (including emergency surgery), as recommended by the doctor/dentist. I accept responsibility for any cost arising from transportation and treatment which is not covered by my insurance.

_____2. I agree to have my child transported by Kingdom Kids program staff if needed.

_____3. I agree that my child may participate in walk around the church property.

_____4. I agree that my child may participate in various Kingdom Kids sponsored activities such as safety programs, speakers, in-center programs, monthly chapel, and parties.

_____5. I agree that photographs and videos may be taken of my child for use and display in the Kingdom Kids program and Family of Christ Lutheran Church.

_____6. I agree that Kingdom Kids staff may use pre-moistened wipes on my child as needed.

_____7. I agree that Kingdom Kids staff may use Skin lotions/cream/Vaseline that I provide, on my child as needed.

_____8. I agree that Kingdom Kids staff may use lip balm that I provide, on my child as needed.

_____9. I agree that Kingdom Kids staff may use sun screen and insect repellant on my child as needed.

_____10. I agree that Kingdom Kids staff may use diaper ointments or creams, that I provide, on my child as needed.

_____11. I agree to release medical, physicals and shot records to Kingdom Kids staff.

_____ _____

Parent signature Date

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

Important Health Problems	Followed By You	Followed By Other Med Source (Name)	Requires Special Attention at Center

Other information helpful to the child care program _____

_____

_____

Phone _____

Signature of Health Source _____ Address _____

Date _____

nter the dates for ach vaccine your child as received to date. pecify the month, day, nd year of each dose uch 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:

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.

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

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		
Haemophilus influenzae 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*)

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 _____

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.

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)

Minnesota Department of **Human Services**

Parental Consent for Swaddling an Infant

Placing a swaddled infant down to sleep in a licensed setting is *not* recommended for an infant of any age* and is prohibited for any infant who has begun to roll over independently.

However, with written consent of a parent or guardian, a license holder may place the infant who has NOT YET BEGUN to ROLL OVER ON ITS OWN down to sleep in a crib, on their back, in a one-piece sleeper equipped with an attached system that fastens securely ONLY across the upper torso, with no constriction of the hips or legs, to create a swaddle.

Any other type of swaddle, including with a blanket, is prohibited.

Prior to any use of swaddling for sleep by a licensed provider, the license holder must obtain informed written consent for the use of swaddling from the parent or guardian of the infant. The parent or guardian must demonstrate to the provider how to safely place baby in the swaddle so it is not too tight or too loose.

I _____ (parent), the parent/guardian of _____ (infant) DOB _____

give written consent to _____ (provider)

To place my infant to sleep in a crib, on their back, in a one-piece sleeper equipped with an attached system ("wings") that fastens securely ONLY across the upper torso to create a swaddle.

_____I verify that my infant has NOT yet begun to roll over.
_____I verify that the provider will only use the one-piece sleeper to swaddle my infant
_____I verify that the provider has a one-piece sleeper with attached "wings" OR
_____I verify that I have provided the one-piece sleeper with attached "wings"
_____I verify that I have demonstrated to the provider how to place baby in the swaddle.
_____I verify that I will immediately notify the provider when my infant has begun to roll over.

Signature of Parent _____ Date _____

Signature of Provider _____ Date _____

At the time that the parent or provider observes that this infant has begun to roll over, this parental consent is no longer valid.

Baby has begun to roll over. Swaddling has been discontinued.

Date: _____ Provider Initials: _____ Parent Initials: _____

*Caring for our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, Third Edition 2012

Minnesota Department of **Human Services**

OPTIONAL FORM FOR PARENT STATEMENT
INFANT LESS THAN SIX MONTHS OF AGE REGULARLY ROLLING OVER

An infant who independently rolls onto its stomach after being placed to sleep on its back may be allowed to remain sleeping on its stomach if the infant is at least six months of age or the license holder has a signed statement from the parent indicating that the infant ***regularly rolls over*** at home. Minnesota Statutes, section 245A.1435

Name of Infant: _____

Date of Birth of infant (MM/DD/YYYY): _____

By completing this form, I (the parent) attest that my infant ***independently and regularly rolls over onto its stomach*** after being placed to sleep on its back. I (the parent) acknowledge that while in the care of the licensed program, my infant will be placed on its back to sleep and that when my infant independently rolls over onto its stomach while sleeping, the license holder may allow my infant to remain sleeping on its stomach.

Name of Parent: _____ **Name of Parent:** _____

Signature of Parent: _____ **Signature of Parent:** _____

Date Signed: _____ **Date Signed:** _____

Please Note: The use of this form for the parent's signed statement is optional.

March 11, 2014 V.1

HEALTH CONSULTANTS FOR CHILD CARE INC.

INFANT DIETARY INSTRUCTION FORM

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

All foods must be tried at home for 3 – 5 days to observe for allergic reactions.
Please initial and date next to each food to be given at the center.
For combination foods, be sure to sign off on all ingredients.

	Initials	Date
PROTEINS:		
Beef		
Cheese		
Chicken		
Cottage Cheese		
Ham		
Turkey		
Tofu		
Yogurt		
FRUITS:		
Apple		
Apricot		
Banana		
Blueberry		
Kiwi		
Mango		
Melons		
Papaya		
Peaches		
Pears		
Plums		
Prunes		
Raspberry		
Strawberry		

	Initials	Date
VEGEATABLES:		
Avocado		
Beans		
Broccoli		
Carrots		
Corn		
Garbanzo		
Green Beans		
Kale		
Lentil		
Peas		
Potato		
Pumpkin		
Spinach		
Squash		
Sweet Potatoes		
Yam		
Zucchini		
GRAINS:		
Barley		
Oatmeal		
Quinoa		
Rice		

Please check all that apply:

Breast Milk _____ Formula _____ Whole Milk _____ Soy Milk _____

I have tried the above foods and give permission for them to be given to my child.
I understand that this list is not inclusive; therefore I give permission for any foods/combinations of foods brought in from home to be given as well.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

Appendix E

INFANT DEVELOPMENTAL HISTORY

(To be completed by parent before admission)

Child's Name: _____ Birthdate: _____ M / F

Start Date: _____ Est. Arrival Time: _____ Est. Departure Time: _____

A. Health

1. Does your child seem well most of the time? Yes / No

2. Is your child taking any medications at this time? (Including aspirin, laxatives, vitamins, etc.) Yes / No

If so, what/why? _____

3. Did your child have as many as three ear infections in the last year? Yes / No

4. Are you concerned about your child's hearing? Yes / No

5. Are you concerned about your child's eyes or vision? Yes / No

6. Has your child ever been seen by a medical specialist? Yes / No

If yes, why and who? _____

7. What arrangements have you made if he/she becomes ill at the center?

_____

8. Does your child have any handicaps/delays? Yes / No

If so, please describe: _____

9. Other illnesses or diseases? Yes / No

If yes, please describe: _____

10. Has your child ever been hospitalized? Yes / No

If yes, for what? _____

11. Has your child had any serious accidents or poisonings? Yes / No

If yes, please describe: _____

12. Does your child chew unusual things such as pencils, cribs, hair, etc.? Yes / No

If yes, please explain: _____

13. Has your child had any of the following? Please Circle. Premature birth / Birth Injury / Head injury / Seizures / trouble breathing at birth / convulsions / allergies (eczema, hives, drugs, wheezing, food intolerance, asthma, insect bites.)

Please describe: _____

_____

B. Developmental History

How do you comfort your child? _____

What are your child's favorite toys? _____

What language is spoken in your home?

C. Sleeping

Do you have any specific ways of helping your child go to sleep? _____

Does your child cry when going to sleep? Yes / No

What is your child's present sleep schedule?

Nigh time from _____ to _____

A.M. nap from _____ to _____

P.M. nap from _____ to _____

Does your child prefer to sleep on his/her stomach**? Side?** Back? (See DHS Alternative Sleep Position form)

Does your child need a pacifier? Yes / No

Does your child have a special blanket? Yes / No

Does your child need a special toy to sleep? Yes / No

D. Feeding

Is your baby breast fed? Yes / No Bottle fed? Yes / No

Type of bottle: _____ Type of nipple: _____ Type of formula: _____

Does your baby need to be burped? Yes / No

What is your child's present eating schedule? (Please specify amounts)

	Juices	Food	Milk/Formula
Breakfast:	_____	_____	_____
Lunch:	_____	_____	_____
Snack:	_____	_____	_____

Does your child have any feeding problems? Yes / No

If yes, please describe: _____

E. Toileting

How frequently does your child have a BM? _____

Appearance of BM? _____

Does your child frequently have diaper rash? Yes / No

How is it treated? _____

_____ _____

Parent Signature Date