



## Birch Grove Community Service Seedlings Enrollment Information

**Child's Legal Name:**

First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Birthdate \_\_\_\_\_ Gender \_\_\_\_\_

Physical Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address \_\_\_\_\_

Home Phone # \_\_\_\_\_

Primary Email Address: \_\_\_\_\_

*(Email address is for Brightwheel Billing and to send home information)*

Parent/Guardian 1: Name \_\_\_\_\_

Place of Employment \_\_\_\_\_ Phone # \_\_\_\_\_

Parent/Guardian 2: Name \_\_\_\_\_

Place of Employment \_\_\_\_\_ Phone # \_\_\_\_\_

List of Person(s) authorized to pick up your child from Saplings:

\_\_\_\_\_

If we are not able to contact parent/guardians, please give a list of relatives, family or friends for us to contact who will care for your child if ill:

Name \_\_\_\_\_ Phone# \_\_\_\_\_

Name \_\_\_\_\_ Phone# \_\_\_\_\_

Name \_\_\_\_\_ Phone# \_\_\_\_\_

Does your child have updated immunizations: \_\_\_\_\_ Please submit records.

Does your child have special circumstances we should know about (example: Special Education IEP, allergies, etc.)?

\_\_\_\_\_

**Data Privacy Tennessee Notice:**

Birch Grove Community School/Service (BGCS) is asking you to provide information, which includes private information, under the Minnesota Government Data Practices Act (MGDPA). BGCS is asking for this private information so that we can fulfill your request to enroll your student at BGCS.

This information will be used to enroll your student at BGCS, create a student file, and fulfill state and federal reporting requirements. This information will also be used to appropriately assist your student in the event of an emergency.

You are not legally required to provide the information that BGCS is requesting and you may refuse to provide some or all of the information requested. However, BGCS may not be able to process your student application for enrollment if you do not provide sufficient information. Failure to provide certain information could result in delays, incorrect enrollment, or cause your student to not be enrolled.

With some exceptions, unless you consent to further release of private information, access to this information will be limited to individuals whose jobs reasonably require access to this information and school officials with an educational need to know. However, state and federal law authorizes release of private information without your consent: to the juvenile justice system, the Minnesota State High School League and if required by a court order, or authorized by other state or federal law.

Parent/Guardian Signature: \_\_\_\_\_

# Admission and Arrangements

PLEASE PRINT. Complete one form for each child in care. This form must be kept on file at the family child care home. Please Note: Pursuant to MN Rules 9502.0405, subpart 4, the provider shall obtain the required information for each child prior to admission and keep the information up to date.

## CHILD INFORMATION

Last Name		First Name	Birthdate (mm/dd/yyyy)	Date Enrolled in Care
Address		City	State	Zip Code

## PARENT OR GUARDIAN # 1

Last Name		First Name	Place of Employment and Work Phone No.	
Address of Employer		City	State	Zip Code
Email		Home Phone		Cell Phone
Address (if different from child)		City	State	Zip Code

## PARENT OR GUARDIAN # 2

Last Name		First Name	Place of Employment and Work Phone No.	
Address of Employer		City	State	Zip Code
Email		Home Phone		Cell Phone
Address (if different from child)		City	State	Zip Code

## EMERGENCY CONTACT FOR CHILD IF PARENTS CAN'T BE REACHED One Contact Required

Last Name		First Name	Relationship and Phone Number	
Address		City	State	By checking I am authorizing this person to pick up my child <input type="checkbox"/>
Last Name		First Name	Relationship and Phone Number	
Address		City	State	By checking I am authorizing this person to pick up my child <input type="checkbox"/>
Last Name		First Name	Relationship and Phone Number	
Address		City	State	By checking I am authorizing this person to pick up my child <input type="checkbox"/>

## EMERGENCY INFORMATION FOR CHILD

Hospital to be used for emergencies		Physician's Name	Telephone	
Address		City	State	Zip Code
Dentist to be used for emergencies		Dentist's Name	Telephone	
Address		City	State	Zip Code
				If you don't have a dentist yet for your child, check this box <input type="checkbox"/>

**CHILD CARE PROVIDER**

Name		License #		
Address		City	State	Zip Code

**ARRANGEMENTS**

Financial Arrangements

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Services Provided (Including Days, Hours, Meals, Etc.)

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Special Conditions ( Special Diet, Special Needs)

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Does Your Child Have Allergies      YES     NO     NOTE: If Yes, Complete the [Allergy Information Form](#)

**LIABILITY INSURANCE NOTIFICATION**

Pursuant to 245A.152(a) A license holder must provide a written notice to all parents or guardians of all children to be accepted for care prior to admission stating whether the license holder has liability insurance. This notice may be incorporated into and provided on the admission form used by the license holder. Select one of the options below.

- I do have liability insurance. A current certificate of coverage of insurance is available for inspection to all parents and guardians of children receiving services and to all parents seeking services from the family child care program. The expiration date is:
- I do not have liability insurance

**PERMISSIONS**

AUTHORIZATION IS HEREBY GIVEN TO THE CHILD CARE PROVIDER AS NAMED IN THE ITEM ABOVE, TO PROVIDE TRANSPORTATION FOR MY CHILD  
 Yes                       No

ANY SPECIAL TRAVEL ARRANGEMENTS

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I have received a copy of the maltreatment of minors mandated reporter policy

AUTHORIZATION IS HEREBY GIVEN TO THE CHILD CARE PROVIDER AS NAMED IN THE ITEM ABOVE, TO OBTAIN EMERGENCY MEDICAL CARE OR TREATMENT IN THE EVENT OF AN EMERGENCY      Yes                       No

**AUTHORIZATION:** We the undersigner hereby agree to abide by the arrangements and authorizations so stated above. We have discussed the information required in the rule part 9502.0405

Signature of Child Care Provider	Date
Signature of Parent / Guardian	Date
Signature of Parent / Guardian	Date



Birch Grove Community School  
Post Office Box 2383  
Tofte, MN 55615  
(218) 663-0170 – Fax (218) 663-7904

## UNIVERSAL OFF CAMPUS PERMISSION FORM

I hereby grant permission for my child \_\_\_\_\_ to participate in classroom field trips, walking trips, bussed field trips, and special classroom activities that may include leaving the school campus. Unless I send a note specifically to exclude my child from any of the above activities, my child will be allowed to accompany his/her class.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

## PHOTO RELEASE FOR MINORS

I, being the Parent/Guardian of \_\_\_\_\_, hereby consent that the photographs of Birch Grove Community School/Community Service activities in which she/he appears may be used by Birch Grove Community School/Community Service, its assigns or successors, in whatever way Birch Grove Community School/Community Service may desire, including but not limited to, audiovisual productions, television, website production, brochures, other media, and other uses as Birch Grove Community School/Community Service deems appropriate.

Birch Grove Community School/Community Service shall not be obligated to provide me with any prior notice of the use of these photographs or films. Futhermore, I hereby consent that such photographs and the plates or films from which they are made shall be the property of Birch Grove Community School/Community Service and that Birch Grove Community School/Community Service shall have the right to duplicate or reproduce such photographs and plates as it may desire, free and clear of any claims whatsoever on my part.

As the Parent/Guardian of \_\_\_\_\_, I have the authority to sign on behalf of my child in this matter.

\_\_\_\_\_  
Signature of Parent/Guardian



## Report Notification Policy – Licensed Child Care Programs

The following form is required by the state to be held in every child's file that participates in our Community Education programs.

### Mandated Reporting:

The reporting of suspected child abuse is a personal obligation as well as a professional and legal one. Minnesota Statute 245A.145, Subdivision 1 requires that any school personnel or child care provider report any form of physical, sexual, or emotional abuse or neglect of any child. When any member of the Birch Grove Community Service/School team have reason to believe, or suspect maltreatment has occurred, we will *immediately*, meaning as soon as possible but definitely within 24 hours, contact and make a report to the following:

1. Cook County Public Health & Human Services- Child Protection 218-387-3620
2. Local Law Enforcement- 218-387-3030
3. Cook County Child Care Licensing- 218-387-3604
4. Lake County Public Health & Human Services Silver Bay Center- 218-226-4443

### Complaints about the program:

Minnesota Statutes 245A.145, Subdivision 1 also requires that parents be informed where they may make concerns or complaints known about the care in the program. Communication between parents and providers is essential to provide consistent, nurturing care. We are confident that we can work with you regarding any concerns you may have. If concerns cannot be satisfactorily resolved you may address your concerns with the following agencies:

1. Cook County Public Health and Human Services- Child Protection 218-387-3620
2. Cook County Child Care Licensing- 218-387-3604
3. Lake County Public Health & Human Services Silver Bay Center- 218-226-4443

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date



## Seedlings Enrollment Questionnaire

First, Middle and Last Legal Name \_\_\_\_\_

Preferred Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Gender \_\_\_\_\_ Male / Female

1. What is any eating/feeding instructions/needs your child has?
2. What is your child's sleeping/napping schedule and routines?
3. Could you explain any diapering/toilet training needs your child has?
4. Does your child have any allergies, medical, development disability, or related conditions or concerns that the provider should be aware of? If yes, please share the information and the instruction on how you like this handled.
5. Do you have a preference in how we should communicate? If so, what might that be? Email, texting, phone call, etc.
6. What languages are spoken in the home?
7. Do you have any cultural traditions you would like to share that represent your family?
8. What day(s) would you like to have your child join the Seedlings program?
9. Any extra information or comments you would like to share?



**Prescription and non-prescription medication administration permission**  
**Family Child Care**

9502.0435 subp. 16 F (1) The provider shall obtain written permission from the child's parent prior to administering prescription and non-prescription medicines, diapering products, sunscreen lotions, and insect repellents. Nonprescription medicines, diapering products, sunscreen lotions, and insect repellents must be administered according to the manufacturer's instructions unless there are written instructions for their use provided by a licensed physician or dentist.

The provider shall obtain and follow written instructions from a licensed physician or dentist prior to administering each prescription medicine. Medicine with the child's name and current prescription information on the label constitutes instructions.

Product	Parent Signature APPROVES	Parent Signature DOES NOT APPROVE
Prescription and Non-Prescription Medicines		
Diapering Products		
Sunscreen Lotions		
Insect Repellents		

Additional information for provider:

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## Swaddling Consent for 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 legal guardian, a license holder may place the infant who has **not yet begun to roll over on their own** down to sleep in a crib, on their back, in a swaddle that is one-piece sleepwear that:

- does not have weighted materials, a hood or a bib;
- wraps over the infant's arms, fastens securely only across the upper torso, with no constriction of the hips or legs; and
- is not so tight that it restricts the infant's ability to breathe or so loose that the fabric could cover the infant's nose or mouth.

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

Prior to any use of swaddling for sleep, the license holder must obtain informed written consent for the use of swaddling from the parent or legal guardian of the infant.

I \_\_\_\_\_, the parent/ legal guardian of \_\_\_\_\_ DOB \_\_\_\_\_  
(Parent or legal guardian) (Infant) (Date of birth)  
 give written consent to \_\_\_\_\_ (Provider)  
 to place my infant to sleep in a crib, on their back, in a swaddle that meets the requirements above.

I verify that my infant has NOT yet begun to roll over.

I permit the provider to only use a swaddle that:

- does not have weighted materials, a hood or a bib;
- wraps over the infant's arms, fastens securely only across the upper torso, with no constriction of the hips or legs; and
- is not so tight that it restricts the infant's ability to breathe or so loose that the fabric could cover the infant's nose or mouth.

I verify that I will immediately notify the provider when my infant has begun to roll over.

Parent or legal guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Provider signature \_\_\_\_\_ Date \_\_\_\_\_

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

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

Date: \_\_\_\_\_ Provider initials: \_\_\_\_\_ Parent or legal guardian initials: \_\_\_\_\_



## Optional Form for Parent Statement: Infant Less Than Six Months of Age Regularly Rolling Over

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

Infant's name: \_\_\_\_\_

Infant's date of birth (MM/DD/YYYY): \_\_\_\_\_

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

Parent or legal guardian name: \_\_\_\_\_

Parent or legal guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or legal guardian name: \_\_\_\_\_

Parent or legal guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*Please note: Documentation is required in order to allow an infant under six months to remain sleeping on their stomach after rolling over. The use of this form is optional to satisfy the documentation requirement.\*\***

# Student Immunization Form

Student Name \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Student Number \_\_\_\_\_

Minnesota law requires children enrolled in school to be immunized against certain diseases or file a legal medical or conscientious exemption.

FOR SCHOOL USE ONLY	
<input type="checkbox"/>	Complete; booster required in _____
<input type="checkbox"/>	In process; 8 mos. expires _____
<input type="checkbox"/>	Medical exemption for _____
<input type="checkbox"/>	Conscientious objection for _____
<input type="checkbox"/>	Parental/guardian consent _____

## 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.

Additionally, if a parent or guardian would like to give permission to the school to share their child's immunization record with Minnesota's immunization information system, they may sign section 3 (optional).

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.

**School Personnel:** Be sure to initial and date any new information that you add to this form after the parent/guardian submits it. Also, record combination vaccines (e.g., DTaP+HepB+IPV, Hib+HepB) in each applicable space.

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
<b>Required</b> (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.)						
<b>Diphtheria, Tetanus, and Pertussis (DTaP, DTP, DT)</b> • for children age 6 years and younger • final dose on or after age 4 years						
<b>Tetanus and Diphtheria (Td)</b> • for children age 7 years and older • 3 doses of Td required for children not up to date with DTaP, DTP, or DT series above						5th dose not required if 4rd dose was given on or after the 4th birthday
<b>Tetanus, Diphtheria and Pertussis (Tdap)</b> • for children in 7th - 12th grade						
<b>Polio (IPV, OPV)</b> • final dose on or after age 4 years						
<b>Measles, Mumps, and Rubella (MMR)</b> • minimum age: on or after 1st birthday						4th dose not required if 3rd dose was given on or after the 4th birthday
<b>Hepatitis B (hep B)</b>						
<b>Varicella (chickenpox)</b> • minimum age: on or after 1st birthday • vaccine or disease history required						
<b>Meningococcal (MCV, MPSV)</b> • for children in 7th - 12th grade • booster given at age 16 years						
<b>Recommended</b>						
<b>Human Papillomavirus (HPV)</b>						
<b>Hepatitis A (hep A)</b>						
<b>Influenza (annually for children 6 months and older)</b>						

## Additional exemptions:

- **Children 7 years of age and older:** A history of 3 doses of DTaP/DTP/DT/Td/Tdap and 3 doses of polio vaccine meets the minimum requirements of the law.
- **Students in grades 7-12:** A Tdap at age 11 years or later is required for students in grades 7-12. If a child received Tdap at age 7-10 years another dose is not needed at age 11-12 years. However, if it was only a Td, a Tdap dose at age 11-12 years is required.
- **Students 11-15 years of age:** A 3rd dose of hepatitis B vaccine is not required for students who provide documentation of the alternative 2-dose schedule.
- **Students 18 years of age or older:** Do not need polio vaccine.

Student Name \_\_\_\_\_

**Instructions, please complete:**

Box 1 to certify the child's immunization status

Box 2 to file an exemption (medical or conscientious)

Box 3 to provide consent to share immunization information (optional)

**1. Certify Immunization Status.** Complete A or B to indicate child's immunization status.

**A. Received all required immunizations:**

I certify that this student has received all immunizations required by law.

\_\_\_\_\_  
Signature of Parent / Guardian OR Physician / Public Clinic

\_\_\_\_\_  
Date

**B. Will complete required immunizations within the next 8 months:**

I certify that this student has received at least one dose of vaccine for diphtheria, tetanus, and pertussis (if age-appropriate), polio, hepatitis B, varicella, measles, mumps, and rubella and will complete his/her diphtheria, tetanus, pertussis, hepatitis B, and/or polio vaccine series within the next 8 months.

The dates on which the remaining doses are to be given are:

\_\_\_\_\_  
Signature of Physician / Public Clinic

\_\_\_\_\_  
Date

**2. Exemptions to School Immunization Law.** Complete A and/or B to indicate type of exemption.

**A. Medical exemption:**

No student is required to receive an immunization if they have a medical contraindication, history of disease, or laboratory evidence of immunity. For a student 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 occurred before September 2010, a parent can sign.)

**B. Conscientious exemption:**

No student 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 student or others they come in contact with. In a disease outbreak schools may exclude children who are not vaccinated 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

**3. Parental/Guardian Consent to Share Immunization Information (optional):**

Your child's school is asking your permission to share your child's immunization documentation with MIIC, Minnesota's immunization information system, to help better protect students from disease and allow easier access for you to retrieve your child's immunization record. You are not required to sign this consent; it is voluntary. In addition, all the information you provide is legally classified as private data and can only be released to those legally authorized to receive it under Minnesota law.

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

\_\_\_\_\_  
Signature of parent or legal guardian

\_\_\_\_\_  
Date