ALBANY AREA SCHOOLS DISTRICT #745 - STUDENT REGISTRATION FORM

STUDENT'S LEGAL LAST NAME | FIRST NAME | MIDDLE NAME

STUDENT'S 911 ADDRESS

STUDENT'S MAILING ADDRESS | APT. NO. | RES. DIST.

CITY | STATE | ZIP CODE | STUDENT HOME PHONE

E-MAIL ADDRESS | MASS CALLING PHONE NUMBER(S) FOR SCHOOL CLOSINGS, ETC.

PHONE #1 | PHONE #2

HAS STUDENT EVER REGISTERED UNDER A DIFFERENT NAME?

☐ NO
☐ YES NAME: _____

STUDENT'S BIRTHDATE

MO. | DAY | YEAR

☐ MALE ☐ FEMALE

STUDENT'S BIRTH PLACE

CITY | STATE | COUNTY

STUDENT'S RACE / ETHNICITY *- Please CIRCLE ONE for each Category:*

AMERICAN INDIAN/ALASKA NATIVE	Y or N	ASIAN	Y or N
BLACK / AFRICAN AMERICAN	Y or N	HISPANIC / LATINO	Y or N
NATIVE HAWAIIAN/PACIFIC ISLANDER	Y or N	WHITE	Y or N

STUDENT LIVES WITH:

☐ BOTH PARENTS ☐ MOTHER ☐ FATHER
☐ MOTHER & STEPFATHER ☐ FATHER & STEPMOTHER ☐ GUARDIAN ☐ FOSTER PARENTS

WHICH PARENT PAYS LUNCH?

MOTHER'S LAST NAME | FIRST NAME | MIDDLE INITIAL

MOTHER'S HOME PHONE | MOTHER'S CELL PHONE

ADDRESS OF MOTHER IF DIFFERENT FROM STUDENT'S

CITY | STATE | ZIP

MOTHER'S EMPLOYMENT | BUSINESS PHONE | EXT.

FATHER'S LAST NAME | FIRST NAME | MIDDLE INITIAL

FATHER'S HOME PHONE | FATHER'S CELL PHONE

ADDRESS OF FATHER IF DIFFERENT FROM STUDENT'S

CITY | STATE | ZIP

FATHER'S EMPLOYMENT | BUSINESS PHONE | EXT.

NAME OF THE ADULT PERSON(S) THE STUDENT LIVES WITH IF OTHER THAN A MOTHER OR FATHER:

LAST | FIRST | DAYTIME PHONE | EXT.

NAME OF A PERSON TO CALL IN AN <u>EMERGENCY</u> OTHER THAN A PERSON THE STUDENT LIVES WITH:

EMERGENCY NAME _____ | DAYTIME PHONE | EXT.

RELATIONSHIP TO STUDENT _____

SIGNATURE | RELATIONSHIP TO STUDENT

STUDENT NAME: _____

ALBANY AREA SCHOOLS DISTRICT #745 - STUDENT REGISTRATION FORM

TODAY'S DATE MO	DAY	YEAR
START DATE MO	DAY	YEAR

GRADE LEVEL	SCHOOL

WAS STUDENT PREVIOUSLY ENROLLED IN ALBANY DISTRICT?

☐ YES ☐ NO

SCHOOL MOST RECENTLY ATTENDED BY STUDENT

DISTRICT NAME OR NO.	SCHOOL NAME

CITY	STATE

DATE LAST ATTENDED			TYPE OF SCHOOL LAST ATTENDED
MO	DAY	YEAR	☐ PUBLIC ☐ NONPUBLIC

HAS THIS STUDENT EVER RECEIVED SPECIAL EDUCATION SERVICES?

☐ NO IF YES, IN WHAT SCHOOL DISTRICT(S)?

☐ YES

MAILING INFORMATION:

SCHOOL MAILINGS MAY BE SENT TO ALTERNATE MAILING ADDRESS IN ADDITION TO OR IN PLACE OF THE STUDENT'S ADDRESS.

CHECK BELOW WHERE TO SEND SCHOOL MAILINGS:

☐ STUDENT ADDRESS ONLY
☐ ALTERNATE MAILING ADDRESS ONLY
☐ BOTH STUDENT ADDRESS & ALTERNATE ADDRESS

PROVIDE CHOSEN ALTERNATE MAILING ADDRESS HERE:

NAME	
ADDRESS	APT. NO.

CITY	STATE	ZIP

IS THIS STUDENT (OR ARE YOU) HISPANIC/LATINO?

(Choose only one)

☐ **No, Not Hispanic/Latino**
☐ **Yes, Hispanic/Latino** (A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race.)

The above part of the question is about ethnicity, not race. No matter what you selected above, **please continue to answer the following** by marking one or more boxes to indicated what you consider your student' (or your) race to be.

WHAT IS STUDEN'T (OR YOUR) RACE? *(Choose one or more)*

☐ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South American (including Central America), and who maintains tribal affiliation or community attachment.)
☐ **Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.)
☐ **Black or African American** (A person having origins in any of the black racial groups of African.)
☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.)
☐ **White** (A person having origins in any of the original peoples of Europe, the Middle East or North Africa.)

HOME LANGUAGE *(IF OTHER THAN ENGLISH):*

CAN AN ADULT IN THE HOME READ ENGLISH?

☐ NO IF NO, WHAT LANGUAGE CAN BE READ?

☐ YES

CITIZENSHIP STATUS OF STUDENT

☐ AMERICAN CITIZEN ☐ STATUS PENDING ENTRANT
☐ STUDENT VISA ☐ VISITOR VISA
☐ REFUGEE ☐ IMMIGRANT ☐ OTHER

NON-CUSTODIAL PARENT RESTRICTIONS: *(IF ANY PROVIDE COURT DOCUMENTS - VISITATION/PHONE ETC.)*

☐ CUSTODY/PARENT RESTRICTIONS APPLICABLE COURT DOCUMENTS HAVE BEEN PROVIDED

☐ NA

DAY CARE PROVIDER (IF ANY)
PHONE
ADDRESS

OTHER CHILDREN IN THIS SAME HOUSEHOLD:

BROTHERS, SISTERS, STEPBROTHERS, STEPSISTERS, FOSTER BROTHERS, FOSTER SISTERS, OR OTHER

FIRST NAME	LAST NAME	BIRTHDATE	SEX	SCHOOL

OFFICE USE ONLY

MN STATE STUDENT ID NUMBER

BIRTHDATE & LEGAL NAME VERIFIED BY:

☐ BIRTH CERTIFICATE
☐ PASSPORT
☐ BAPTISMAL RECORD
☐ OTHER

HAS IMMUNIZATION INFORMATION BEEN GIVEN TO THE SCHOOL'S HEALTH OFFICE? INITIALS

☐ YES ☐ NO ☐ INCOMPLETE ☐ NA

WHO IDENTIFIED STUDENT'S ETHNICITY?

☐ PARENT/GUARDIAN/STUDENT OR OTHER FAMILY MEMBER
☐ SCHOOL STAFF ☐ OTHER

WHITE - BLDG SEC. / YELLOW - TRANSPORTATION / PINK - NURSE

KINDERGARTEN TRANSPORTATION INFORMATION

Please fill in all information below:

CHILD'S NAME: _____

PARENT'S NAME: _____

Transportation Plan for Kindergarten Students on Days Attending School.

Please Check One:

Child picked up by bus at: ___Home ___Day care ___Transport by parents
Child dropped off by bus at: ___Home ___Day care ___Transport by parents
Child will attend Afterschool Kids Co. ___AT Avon Elem OR ___AT Albany Elem

Name of Student/Sibling who may also ride this bus (if known): _____

Additional comments regarding your Kindergartner's transportation plan: _____

_____

Name and Address of Day Care Provider on Kindergarten school days: _____

_____

Telephone number of Day Care Provider: _____

Directions from School to Home: _____

_____

Directions from School to Day Care: _____

_____

ANY CHANGE FROM ABOVE INFORMATION REQUIRES A WRITTEN NOTE TO THE TRANSPORTATION OFFICE:

Albany Area Schools
P.O. Box 40
Albany, MN 56307

Director: Doug Konz
Phone: 320-845-2171 x 5800

Kindergarten Information Form

Child's Full Name:_____
Child's Full Birthdate: _____
Medical or Allergy Concerns: _____

Father's Name:_____
Father's Address: _____
Workplace: _____
Cell Phone Number: _____
Work Number: _____
Parent Email: _____

Mother's Name:_____
Mother's Address: _____
Workplace: _____
Cell Phone Number: _____
Work Number: _____
Parent Email: _____

If you cannot be reached, please list the name and phone numbers of your daycare if applicable and at least two other emergency contact people.

Name:_____ Relationship:_____
Home Number: _____ Cell Number: _____

Name:_____ Relationship:_____
Home Number: _____ Cell Number: _____

Name:_____ Relationship:_____
Home Number: _____ Cell Number: _____

After School Plans:
Bus Number: _____ Days Attending Kid's Company: _____
Picked up by: _____ Walking to/with: _____

Kindergarten Information Form

Please list all of the adults living in your child's household:

Name	Relationship

Please list all of the children living in your child's household:

Name	Relationship

Please describe any health concerns.

Please circle the programs that your child has been involved with.

Daycare ECFE/ECSE/Preschool Learning Readiness Head Start

What are your child's major strengths?

Describe your child's feelings about school.

How does your child get along with other children?

Please describe recent family changes or events. (e.g. death, divorce, new sibling, moving).

How do you feel that I can best help your child this year?

Is there anything else that would be beneficial for me to know about your child?

ALBANY AREA SCHOOLS

Kindergarten Health Record

Parent or guardian to complete this section before student is examined by Health Care Provider

Name_____ M___F___Date of birth_____

Address_____ City_____ Phone_____

Parent(s)/Guardian_____

Physician_____ Dentist_____

Significant Health History

Parent or guardian to check conditions that apply & enter approximate date of diagnosis

	CHECK THOSE THAT APPLY	DATE		CHECK THOSE THAT APPLY	DATE
	Allergy, specify food, drug, environmental			Diabetes	
	Asthma			Emotional problem, specify	
	Behavioral disorder, specify			Orthopedic problem, specify	
	Congenital condition, specify			Seizure disorder	
	Chicken pox			Surgery, specify	
	Chiropractic care for, specify			Other	

Health Exam

Physician to complete

Height	Eyes	Heart	Allergies
Weight	Ears	Neurologic	Nutrition
Heart rate	Nose	Bones/Joints	TB test
BP	Throat	Scoliosis	Date:
U/A	Glands	Skin	Result:
Hgb	Lungs	Hernia	

Significant developmental history _____

Social/emotional problems _____

Hearing _____ Speech _____ Vision _____

List any special health concerns, recommendations or comments _____

_____

List conditions that may limit participation in:

Classroom activity _____

Physical Education _____ Competitive sports _____

Approved for:

___ Full activity ___ Limited activity

_____ _____

Health Care Provider Date

5/07

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
( ) Complete, booster required in _____
( ) In process, 8 mos. expires _____
( ) Medical exemption for _____
( ) Conscientious objection for _____
( ) 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.

Vaccine	DO NOT USE	1st Dose	2nd Dose	3rd Dose	4th Dose	5th Dose
		Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	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, DT) • for children age 6 years and younger • final dose on or after age 4 years						
Tetanus and Diphtheria (Td) • 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						
Tetanus, Diphtheria and Pertussis (Tdap) • for children in 7th - 12th grade						
Polio (IPV, OPV) • final dose on or after age 4 years						
Measles, Mumps, and Rubella (MMR) • minimum age: on or after 1st birthday						
Hepatitis B (hep B)						
Varicella (chickenpox) • minimum age: on or after 1st birthday • vaccine or disease history required						
Meningococcal (MCV, MPSV) • for children in 7th - 12th grade • booster given at age 16 years						
Recommended						
Human Papillomavirus (HPV)						
Hepatitis A (hep A)						
Influenza (annually for children 6 months and older)						

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 concientious)
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 occured 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

Please also submit a copy of the students Birth Certificate