THE NEST
at Rochester Catholic Schools

ROCHESTER CATHOLIC SCHOOLS

PRESCHOOL & EXTENDED CARE A– PIP Form

Updated March 2022

Please complete a new form each year _____ / _____
Month Year

CHILD INFORMATION

NAME _____ **BIRTHDATE** _____

NAME YOUR CHILD WOULD LIKE TO BE CALLED AT SCHOOL: _____

GENDER ☐ Male ☐ Female

LANGUAGE(S) SPOKEN IN THE HOME _____

IF YOUR CHILD LIVES IN MORE THAN ONE HOUSEHOLD, PLEASE DESCRIBE:

_____

My child has special learning, developmental, behavioral, health, dietary, or medical needs. **Please complete information on back.** ☐ Yes ☐ No

PARENT/GUARDIAN INFORMATION

ADULT 1 *Primary Contact

NAME _____

ADDRESS _____

_____
City State Zip Code

HOME # _____

CELL # _____

WORK # _____

EMAIL _____

RELATIONSHIP TO CHILD _____

*__Primary contact__ will be responsible for receiving program updates, scheduling, and billing communications.

ADULT 1 is authorized to pick child up from program.

ADULT 2 ☐ Check if address and home # are same as **ADULT 1**

NAME _____

ADDRESS _____

_____
City State Zip Code

HOME # _____

CELL # _____

WORK # _____

EMAIL _____

RELATIONSHIP TO CHILD _____

☐ Check box if **ADULT 2** would also like to receive communications.

☐ Check box to authorize **ADULT 2** to pick child up from program.

HEALTH AND SPECIAL NEEDS INFORMATION

PLEASE LIST AND DECRIBE ANY OF THE FOLLOWING:

FOOD ALLERGIES _____

DRUG ALLERGIES _____

OTHER SENSITIVITIES _____

OTHER RESTRICTIONS OR CONCERNS _____

_____

DOES YOUR CHILD USE AN EPI-PEN? Yes No

DOES YOUR CHILD REQUIRE AN INHALER OR NEBULIZER? Yes No

DOES YOUR CHILD RECEIVE REGULAR MEDICATION? Yes No

IF YES, PLEASE DESCRIBE _____

PLEASE DESCRIBE ANY SPECIAL LEARNING, DEVELOPMENTAL, OR BEHAVORIOL NEEDS:

_____

_____

EARLY CHILDHOOD SCREENING

HAS YOUR CHILD HAD AN EARLY CHILDHOOD SCREENING? Yes No

If your child has not been screened, **PLEASE CALL** the Northrop Education Center at **507-328-4004** to set up an appointment. The best time to schedule your child's screening is after their third birthday and before the first day of Kindergarten. This is a requirement of our local district.

MEDICAL INFORMATION – MUST BE COMPLETED IN FULL

NAME/CLINIC OF CHILD'S DOCTOR:

_____

PHONE # _____

ADDRESS _____

NAME/CLINIC OF CHILD'S DENTIST:

_____

PHONE # _____

ADDRESS _____

CHECK HOSPITAL OF PREFERENCE: ☐ Mayo Clinic/St. Mary's ☐ Olmsted Medical Center

MEDICAL AUTHORIZATION:

In the event of an emergency and I am delayed in arriving, I authorize the nearest source of medical care to treat my child.

_____ _____

Parent Signature Date

EMERGENCY CONTACT INFORMATION

IF PARENT CANNOT BE REACHED

EMERGENCY CONTACT ADULT 1

☐ Check box to authorize **ADULT 1** to pick child up from program.

NAME _____

***ADDRESS** _____

_____

City State Zip Code

HOME # _____

CELL # _____

WORK # _____

RELATIONSHIP TO CHILD _____

EMERGENCY CONTACT ADULT 2

☐ Check box to authorize **ADULT 2** to pick child up from program.

NAME _____

***ADDRESS** _____

_____

City State Zip Code

HOME # _____

CELL # _____

WORK # _____

RELATIONSHIP TO CHILD _____

***ADDRESSES ARE REQUIRED** for Emergency Contacts.

AUTHORIZED/UNAUTHORIZED ADULTS

ADULTS MUST REPORT TO STAFF AND MAY BE ASKED TO PROVIDE DRIVER'S LICENSE IF UNKNOWN TO STAFF.

ADDITIONAL INDIVIDUAL AUTHORIZED TO PICK CHILD UP FROM PROGRAM:

NAME _____

HOME # _____

CELL # _____

RELATIONSHIP TO CHILD _____

INDIVIDUAL NOT AUTHORIZED TO PICK CHILD UP FROM PROGRAM:

NAME _____

RELATIONSHIP TO CHILD _____

ADDITIONAL INFORMATION _____

_____

ORDER OF CONTACT FOR ILL CHILD OR EMERGENCY

WHO SHOULD BE CONTACTED FIRST IN AN EMERGENCY?

Numerically order the **best way to contact** _____ _____

Name Relationship

☐ Cell phone _____

☐ Work phone _____ Employer _____

☐ Home phone _____ **Special Notes**:

SIBLINGS

BROTHERS AND/OR SISTERS:

NAME(S) AGE(S) SCHOOL(S)/GRADE

ALL ABOUT MY CHILD

PLEASE ATTACH ADDITIONAL PAPER IF NEEDED

Child's previous preschool or childcare experience:

Activities at which my child feels successful:

Activities which my child finds difficult:

My child is especially interested in:

My child is: ☐ right-handed ☐ left-handed ☐ not sure

Socially my child is:

Describe your child's ability to care for his or her own toileting needs:
Preschool (age 3) and Pre-Kindergarten (ages 4/5) must be fully toilet trained to attend **The Nest.*

Child's attitude about attending preschool (and/or childcare if applicable):

Activities your child is looking forward to while at preschool (and/or childcare if applicable):

My child will typically be brought to school by: _____

My child will typically be picked up from school by: _____

Additional information you would like to share (pets, extended family, etc. that will help us get to know your child):

NAME OF STUDENT ENROLLED _____

First Last

PROGRAM AGREEMENTS

Yes No **PHOTO/MEDIA**
I give permission for RCS to use pictures that include my child for the purpose of community, educational, or promotional materials via memory books, school-wide broadcasts, or the RCS website. ***Select "no" if you do not want your child included in these opportunities.***

Yes No **PHOTO/CLASSROOM COMMUNICATIONS**
I give permission for my child to be photographed (or included in a video) for use by teacher for classroom communications only. Photos and video segments will **NOT** include the name of any child.

Yes No **SUNCREEN** *Extended Care, only
I consent to the application of sunscreen on my child while attending the RCS childcare and/or summer programs. If your child has sensitive skin, please provide personal sunscreen labeled with child's first and last name.

Yes No **WATER PLAY** *Summer Care, only
I consent to the participation of my child in light water play (buckets, sprinkler spray, etc.) while attending the RCS Summer Care Program. Please keep an extra set of dry clothes on hand at all times.

ACCEPTANCE OF RESPONSIBILITIES

Yes No **SPECIAL NEEDS**
I understand that it is my responsibility to inform RCS of any special learning and/or developmental needs of my child along with any services currently being received.

Yes No **CONTACT INFORMATION UPDATES**
I understand that it is my responsibility to inform RCS of any changes to child, parent/guardian, or emergency contact information.

Yes No **PROGRAM TERMS/HANDBOOK**
I understand that I am enrolling my child in **THE NEST** Early Learning Academy with Rochester Catholic Schools. I have received and agree to abide by the program practices and procedures as outlined in the PRESCHOOL & CHILDCARE HANDBOOK (available on RCS website). I understand and agree to follow the guidelines set forth for attendance, ill child, toileting, behavior, billing, scheduling, cancellations, and penalties for late payment or child pick-up.

Yes No **REQUIRED FORMS**
I understand that the following forms **MUST BE COMPLETE AND SUBMITTED** by the stated school due date to maintain my enrollment status: Immunization Record, Health Care Summary, and this Preschool Information Packet (PIP) Form.

PLEASE SIGN BELOW TO ACKNOWLEGE YOUR AGREEMENT AND ACCEPTANCE:

_____

(Primary Contact) Parent/Guardian Signature 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

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)

PRE-SCHOOL 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 Attenttion At Center

Other information helpful to the child care program_____

_____

Signature of Health Source_____ Date_____

Address_____ Phone _____

THE NEST
EARLY LEARNING ACADEMY

Authorization for Administration of Medication (Staff Administration)

- Page 1 and 2 Must copy back to back
- A separate authorization form is REQUIRED for EACH medication
- This form must be completed on an annual basis

Full Name of Child: _____ Birthday: _____

Name of Medication	
Reason for Medication	
Possible Side Effects	
Route of Administration (circle one)	Oral Rectal Topical Inhaled Injected Eye/Nose/Ear Other (explain):

Amount/Dose	Frequency/Time	Start Date	End Date	Expiration Date

Complete section below for PRESCRIPTION MEDICATION; or OVER-THE-COUNTER MEDICATION to be administered in an inconsistent manner with the package labeling.

Doctor Signature:	Date:
Doctor Printed Name:	
Clinic:	Phone:

I, (Parent/Guardian printed first and last name) _____, give permission and authorization for Holy Spirit Catholic School personnel to administer the medication named above during school hours, including field trips, to my child,

(Child's printed first and last name) _____, in the manner stated. I release any liability in relation to the administration of this medication. I also acknowledge that I, the parent/guardian, have given the first dose of this medication without any allergic or unexpected reactions. I will immediately notify the school of any change with my child's prescribed or over-the-counter medication, including but not limited to, side effects, dosage, frequency or duration.

Parent/Guardian Printed Name:_____ Date Signed: _____

Parent/Guardian Signature: _____

NOTE: ***All medication must be brought to school by a parent/guardian in the original container. Prescription medication must be labeled for the student by a pharmacy in accordance with law and must be administered to the student consistent with the instructions on the label. Mixed dosages in a single container will not be allowed for use at school (example: 10mg tablets and 2mg tablets in the same container).***

Teacher's Printed Name authorized to administer medication	Teacher's Signature authorized to administer medication

*****PLEASE SEE AND COMPLETE BACK SIDE****

7 Rights of Medication Administration must be checked every time!
1. Right Child 2. Right Medication 3. Right Dose 4. Right Time 5. Right Route 6. Right Documentation 7. Right Reason

FOR CONTROLLED SUBSTANCES: ***Two staff members*** must intake controlled substances and sign off the amount received.

Date	Dose	Route	Time	Dispensed By (signature must match authorized teacher listed on page 1)	Amount on Hand (For Controlled Substance Only)	Amount Given (For Controlled Substance Only)	Amount Remaining (For Controlled Substance Only)	Signature of 2nd Staff Member (For Controlled Substance Only)	Comments

****This page MUST be copied back to back with Page 1 Authorization for Administration of Medication (Staff Administration)****

Minnesota Language Survey

Minnesota is home to speakers of more than 100 different languages. The ability to speak and understand multiple languages is valued. The information you provide will be used by the school district to see if your student is multilingual. In Minnesota, students who are multilingual may qualify for a Multilingual Seal upon further assessment. Additionally, the information you provide will determine if your student should take an English proficiency test. Based upon the results of the test, your student may be entitled to English language development instruction. **Access to instruction is required by federal and state law. As a parent or guardian, you have the right to decline English Learner instruction at any time.** Every enrolling student must be provided with the Minnesota Language Survey during enrollment. Information requested on this form is important to us to be able to serve your student. Your assistance in completing the Minnesota Language Survey is greatly appreciated.

Student Information	
Student's Full Name: (Last, First, Middle)	Birthdate AND Student ID:

	Check the phrase that best describes your student:	**Indicate the language(s) other than English in space provided:**
1. My student first learned:	___ language(s) other than English. ___ English and language(s) other than English. ___ only English.	
2. My student speaks:	___ language(s) other than English. ___ English and language(s) other than English. ___ only English.	
3. My student understands:	___ language(s) other than English. ___ English and language(s) other than English. ___ only English.	
4. My student has consistent interaction in:	___ language(s) other than English. ___ English and language(s) other than English. ___ only English.	

Language use alone does not identify your student as an English learner. If a language other than English is indicated, your student will be screened for English language proficiency.

Parent/ Guardian Information	
Parent/Guardian Name (printed):	
Parent/Guardian Signature:	Date:

* All data on this form is private. It will only be shared with district staff who need the information to best serve your student and for legally required reporting about home language and service eligibility to the Minnesota Department of Education. At the district and at the Minnesota Department of Education, this information will not be shared with other individuals or entities, except if they are authorized by state or federal law to access the information. Compliance with this request for information is voluntary.