The NEST at RCS Enrollment Forms Checklist

Find below your NEST document checklist

Please print all forms along with this cover page.

THE NEST
at Rochester Catholic Schools

CHILD'S NAME _____

☐ **Returning Student** ☐ **New Student**

☐ **ANNUAL PRESCHOOL INFORMATION PACKET (A-PIP)** (Pages 2-9)

- Must be completed annually
- Complete all pages
- If your child requires additional health forms they are located at the end of the packet (pages 17-22)

*Educators will review with family

☐ **BIRTH CERTIFICATE**

- *New families only*

☐ **IMMUNIZATION FORMS** (2 pages)

- New Students
  - Complete both pages
  - If you have a copy of your child's immunization history, this may be used instead of completing
  - Parent signature required
- Returning Students
  - If you are re-enrolling with the NEST and you do not have updates to your immunization records, we do not need new forms

☐ **AUTHORIZATION FOR ADMINISTRATION OF MEDICATION** (2 pages)

- Please complete only If your child needs medications administered during their time in our program
- Complete pages 12 & 13 for each medication to be administered. Please print additional copies for more than 1 medication

☐ **PRESCHOOL HEALTH CARE SUMMARY** (1 page)

- Must be completed every two years, or annually if changes have occurred

☐ **MINNESOTA LANGUAGE SURVEY** (1 page)

- New students only

☐ **EXTENDED DAY PROGRAM HOURS** (1 page)

- Complete only if your family has enrolled in an extended day program

☐ **ADDITIONAL HEALTHCARE FORMS**

- Complete only if your child needs additional healthcare

PRESCHOOL HANDBOOK

- For your reference only

Please complete and bring all forms and "*pop-in*" to your school office during

Pop-in for Pre-school

Monday, May 1st or Tuesday, May 2nd

between the hours of

8:00 a.m. & 3:00 p.m.

THE NEST
at Rochester Catholic Schools

ROCHESTER CATHOLIC SCHOOLS
Annual Preschool Information Packet
A-PIP 2023-24

This form must be completed on an annual basis

*Updated March 2023

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 YOUR LIVING ARRANGEMENTS:

_____

My child has special learning, developmental, behavioral, health, dietary, or medical needs. **Please explain on Page 2.**
Additional forms may be needed

☐ OK

PARENT/GUARDIAN INFORMATION

ADULT 1 *Primary Contact will be contacted first in emergencies.

NAME _____

ADDRESS _____

_____

City State Zip Code

EMPLOYER _____

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 *WIl be contacted if Adut 1 cannot be reached

NAME _____

ADDRESS _____

_____

City State Zip Code

EMPLOYER _____

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.

PLEASE LIST AND DESCRIBE BELOW. IF NONE KNOWN, PLEASE USE N/A.

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 BEHAVIORAL NEEDS:

_____

_____

_____

_____

_____

_____

_____

NOTE: Additional forms for health needs are at the end of this packet.

EARLY CHILDHOOD SCREENING

HAS YOUR CHILD COMPLETED THE EARLY CHILDHOOD SCREENING?

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 and before entering Kindergarten

MEDICAL INFORMATION MUST BE COMPLETED IN FULL

NAME CHILD'S DOCTOR: _____

NAME OF CHILD'S DENTIST: _____

NAME OF PROVIDER'S CLINIC: _____

NAME OF PROVIDER'S OFFICE: _____

PHONE # _____

PHONE # _____

ADDRESS _____

ADDRESS _____

CIRCLE HOSPITAL OF PREFERENCE: Mayo Clinic/St. Marys 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. Please sign below.

_____ _____

Parent Signature Date

EMERGENCY CONTACT INFORMATION

IF PARENT CANNOT BE REACHED

*Please note emegency contacts will be called if parents cannot be reached. We ask for this person to be a local contact in case student pick up is needed.

EMERGENCY CONTACT ADULT 1

NAME _____

ADDRESS _____

_____

City State Zip Code

HOME # _____

CELL # _____

WORK # _____

RELATIONSHIP TO CHILD _____

*Please note emegency contacts will be called if parents cannot be reached. We ask for this person to be a local contact in case student pick up is needed.

EMERGENCY CONTACT ADULT 2

NAME _____

ADDRESS _____

_____

City State Zip Code

HOME # _____

CELL # _____

WORK # _____

RELATIONSHIP TO CHILD _____

AUTHORIZED ADULTS

ADULTS WILL BE ASKED TO PROVIDE DRIVER'S LICENSE IF UNKNOWN TO STAFF.

ADDITIONAL INDIVIDUALS AUTHORIZED TO PICK CHILD UP FROM PROGRAM:

NAME _____

CELL # _____

WORK # _____

RELATIONSHIP TO CHILD _____

NAME _____

CELL # _____

WORK # _____

RELATIONSHIP TO CHILD _____

UNAUTHORIZED ADULTS

INDIVIDUALS NOT AUTHORIZED TO PICK CHILD UP FROM PROGRAM:

NAME _____

RELATIONSHIP TO CHILD _____

ADDITIONAL INFORMATION _____

_____

NAME _____

RELATIONSHIP TO CHILD _____

ADDITIONAL INFORMATION _____

_____

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:

Activities your child is looking forward to while at preschool:

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

SIBLINGS

BROTHERS AND/OR SISTERS:

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

NAME OF STUDENT ENROLLED _____

First Last

AUTHORIZATIONS

Circle "no" if you do not want your child included in these opportunities.

YES NO **RCS FAMILY DIRECTORY**
I give permission for my family information to be included in the school directory.

YES NO **RCS STUDENT BIRTHDAY**
I give permission for my child's birthday information to be published to the school community (We typically read child's name on announcements, post their name on the birthday bulletin board, and post in classroom.)

YES NO **RCS PUBLIC RELATIONS AUTHORIZATION**
I give permission for RCS to take photos of my child.
We take many pictures throughout the year that show students learning and participating in various school activities. These pictures may be used in our memory books, on our website, in our Weekly Broadcasts and for promotional materials. We do not typically identify students by name. In the event we identify by name, we state first name only.

YES NO **RCS LIVE-STREAM**
I give permission for my child to be included in live-streamed classroom and school events.

YES NO **RCS EDUCATION BASED RESEARCH**
I give permission for my child to be included in education-based research.
RCS supports our educators in their goals of seeking higher education and participating in professional development. At times, our educators may conduct educational research in our classrooms as part of their professional studies and data collection.

YES NO **SUNSCREEN**
I consent to the application of sunscreen on my child while attending The NEST. If your child has sensitive skin, please provide personal sunscreen labled with your child's first and last name.

YES NO **WATER PLAY**
I consent to the participation of my child in light water play (buckets, sprinkler spray, etc.) while attending The NEST.

ACCEPTANCE OF RESPONSIBILITIES

IN-SCHOOL FIELD TRIPS

I understand that while attending the NEST at RCS, my child may take in-school field trips to other classrooms and/or outside to explore our campus grounds, both inside and outside the fenced area of the property.

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.

CONTACT INFORMATION UPDATES

I understand that it is my responsibility to inform RCS of any changes to child, parent/guardian, or emergency contact information.

PROGRAM TERMS/HANDBOOK

I understand that I am enrolling my child in **THE NEST** preschool progam with Rochester Catholic Schools. I have read, and agree to abide by the program practices and procedures as outlined in The NEST Preschool 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.

REQUIRED FORMS

I understand that the A-PIP Packet **MUST BE COMPLETED AND SUBMITTED** by the stated school due date to maintain my enrollment status.

RCS PESTICIDE NOTIFICATION

I understand as required by law, schools that apply certain pesticides on school property must maintain an estimated schedule of pesticide applications and make the schedule available to parents and guardians. RCS is under a Pest Management Program (IPM). This means that our schools will be inspected quarterly for rodents, insects and other pests in and around the building. The pest management program consists of inspection, monitoring, recommendations for sanitation and maintenance practices, utilization of non-chemical measures and applications of EPA registered pest control materials, when needed. State law also requires that you be told that the long-term health effects of children from the applications of such pesticides or the class of chemicals to which they belong may not be fully understood.

Please sign this agreement below.

(Primary Contact) Parent/Guardian Signature Date

Immunization Form

Name_____ Birthdate_____

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.

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)

ROCHESTER CATHOLIC SCHOOLS

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: _____ Birth Date:_____

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 (school name) _____ 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)****

ROCHESTER CATHOLIC SCHOOLS
Pre-school Health Care Summary

This form must be completed every two years,
or annually if there are changes

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 for The NEST to know about this child: _____

_____

Signature of Health Source _____ Date _____

Address _____ Phone _____

Rochester Catholic Schools
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.

ROCHESTER CATHOLIC SCHOOLS

Extended Day Program Hours

This form must be completed on an annual basis

If your family has enrolled in our "Extended Day" program, we ask that you complete this form. In an effort to coordinate staffing and programming needs during our Extended Day hours, we would appreciate knowing your family's estimated drop off and pick up times.

Thank you for your assistance in helping us better meet your child's needs.

Child's Name_____

Your Child's Age on Sept. 1, 2023: _____

	Extended Day Morning (Programing begins at 6:30 a.m.)	**Extended Day Afternoon** (Programming ends at 6:00 p.m.)
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

DEPARTMENT OF HUMAN SERVICES

DHS-7995-ENG 12-19

Individual Child Care Program Plan

Licensed Child Care Centers

An individual child care program plan (ICCPP) is used to describe a child's individual physical, social, or emotional needs and document the center's plan to carry out the implementation of accommodations to meet the individual needs of the child in the child care center setting. An ICCPP **must** be coordinated with an existing plan and/or the child's Health Care Summary to ensure that the accommodations are aligned with existing recommendations from case management professionals and/or physicians and is suitable to the child care center environment. An ICCPP may be developed to address a child's individual needs as determined in the referral process or in coordination with an outside professional. Examples of some plans that address the individual needs of children are an Individualized Education Plan (IEP), an Individual Family Service Plan (IFSP), an Individual Service Plan (ISP) or a 504 Plan. A child's individual needs could also be identified on the child's Health Care Summary or documentation from the child's medical provider. For a child with a known allergy, all documentation requirements of Minnesota Statutes, section 245A.41 must be met; see allergy section of this form.

Child Information

Child's Full Name

Child's Date of Birth

Identification of Individual Needs

This ICCPP is being developed because: (Check all that apply)

- ☐ Accommodations would improve outcomes for child's development or behavior
- ☐ Child is in referral and needs accommodations
- ☐ Child has an IEP/IFSP/ISP/504
- ☐ Child is receiving outside services/therapy
- ☐ Other: _____

Information has been provided by: (Check all that apply)

- ☐ Licensed Physician
- ☐ Licensed Psychiatrist
- ☐ Licensed Consulting Psychologist
- ☐ Parent/Guardian
- ☐ Other: _____

Describe how the child's needs impact their ability to engage in the daily routine of the child care environment?

If the child has a special need that requires accommodation for something that doesn't occur while in child care, it would not need to be included on this form.

Describe any known situations or environments that may increase stress or present additonal challenges for the child?

What accommodations will be made that are appropriate for the child care center environment?

What modifications or accommodations are needed while the child is engaged in classroom, curriculum, and routine activities (i.e. nap, toileting, mobility, meals)?

What modifications or accommodations are needed for outdoor play, field trips, or transportation? Check here if this does not apply. ☐

What training, staffing, or materials may be needed to support the above accommodations? Check here if this does not apply. ☐

Escalation Planning

Describe any situations or behaviors when the above accommodations may not be adequate to meet the individual needs of the child. Check here if this does not apply. ☐

What additional supports are recommended? What will be done to provide additional support? Check here if this does not apply. ☐

Individual Child Care Program Plan for Allergies

Licensed Child Care Centers

The child care center can use this form to document 1) allergy information, 2) medication to respond to an allergic reaction, and 3) emergency contact information for allergy prevention and response. Complete the Individual Child Care Program Plan for Allergies (ICCPP-A) from the allergy information obtained from parents. Documentation of any known allergy must be obtained before the center cares for the child. The ICCPP-A must be available at all times on site, when on field trips, or during transportation. Food allergy information must be readily available to staff in the area where food is prepared and served to the child. All staff who interact with this child must review and follow this plan. **Use a separate form for each allergy, even if the same child has more than one identified allergy.**

Allergy prevention and response requirements are found in MN Statutes, section 245A.41, subdivision 1.

Child Information

Child's Full Name | Child's Date of Birth

Date ICCPP-A was developed

Initial Date | Print Name of Center Representative that developed this ICCPP-A | Signature of Center Representative that developed this ICCPP-A

Allergy Information

1. Describe the allergy. **Use a separate form for each known allergy.**

2. What triggers the allergy?

3. What symptoms may the child display when exposed to an allergen or trigger? (Check all that apply)

- ☐ No history of symptoms or unknown
- ☐ Mouth: Itching; tingling; swelling of lips, tongue or mouth ("mouth feels funny")
- ☐ Skin: Hives; itchy rash; swelling of face or extremities
- ☐ Gut: Nausea; abdominal cramps; vomiting; diarrhea
- ☐ Throat: Difficulty swallowing; hoarseness; hacking cough
- ☐ Lung: Shortness of breath; repetitive coughing; wheezing
- ☐ Heart: Weak or fast pulse, low blood pressure; fainting; pale; blueness
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

What techniques are used to avoid an allergic reaction?

What procedures will be taken to respond to an allergic reaction for this child?

Medications for Responding to an Allergic Reaction- Call 911 if Epinephrine is administered

What medication(s), if applicable, are required for response to an allergic reaction for this child? *Note: If medication provided, refer to Minnesota Rules, chapter 9503.0140, subpart 7 for administration of medication requirements.*

Medication | Dosage

Medication | Dosage

Medication | Dosage

Doctor Information - Call 911 for EMERGENCIES

Doctor's Name | Doctor's Phone Number

Date ICCPP/ICCPP-A Created

Date ICCPP Created	Signature of Center Representative	Position of Center Representative

ICCPP Reviews and Updates

Review

How long has this ICCPP been implemented at the center?

What has worked?

What improvements could be made?

Is there a continued need for an ICCPP for this child? (yes or no)

If yes, what changes to the ICCPP will be made? If no, check here. ☐

Date	Signature of Center Representative Reviewing ICCPP	Signature of Parent / Guardian Reviewing ICCPP

Staff that work with child and have reviewed this ICCPP

Review Date	Print Staff Name	Signature of Staff Reviewing ICCPP

Purpose of this Form: To assist licensed child care centers in planning for the individual program needs of children with special needs as outlined in MN Rules 9503.0065, 9525.004 to 9525.0036, and MN Statutes, section 125A.02, subdivision 1 and 125A.05. The Individual Child Care Program Plan (ICCPP) must be in writing and specify methods of implementation. This plan must be reviewed annually and followed by all staff who interact with the child. The ICCPP must be developed in coordination with reports from a local school district, licensed physician, psychiatrist, psychologist, and with the child's parent or legal guardian, if such reports are available for the child. An ICCPP can also be developed based on the recommendation of consulting physicians, psychiatrists, and psychologists.

ANAPHYLAXIS EMERGENCY CARE PLAN

Date of Plan: / / This plan is valid for the current school year: 20 - 20

STUDENT INFORMATION

Name DOB / / Grade School

ALLERGY INFORMATION

Known Allergen(s):

Asthma* ☐ Yes ☐ No * high risk for severe reaction

Signs and Symptoms of Anaphylaxis:

MOUTH
itching, swelling of lips and/or tongue

SKIN
rash, itching, hives, redness, swelling

LUNG
shortness of breath, cough, wheeze

THROAT
itching, tightness/closure, hoarseness

GUT
nausea, vomiting, abdominal cramps

HEART
confused, weak pulse, dizziness, passing out

The symptoms of a reaction are not always consistent and could include any of the above.
The severity of symptoms can change quickly.
All of the symptoms can potentially progress to a life-threatening situation!

ANAPHYLAXIS EMERGENCY PROTOCOL

1. **<u>Inject epinephrine</u> (as ordered below) <u>IMMEDIATELY!</u>**
2. **CALL 911 (Request an ambulance and specify that child is having an anaphylactic reaction)**
3. **Give another epinephrine dose within 15 minutes if symptoms return or worsen and emergency services have not arrived.**
4. **Alert contact(s):**

Parent/Guardian	Phone	Phone (C)
Parent/Guardian	Phone	Phone (C)
Emergency Contact	Phone	Phone (C)

Preferred hospital

PHYSICIAN'S AUTHORIZATION FOR MEDICATION ADMINISTRATION

EPINEPHRINE DEVICE	DOSAGE	TIME	COMMON SIDE EFFECTS/SPECIAL INSTRUCTIONS

Self-Carry ☐ Yes ☐ No — If yes, I understand this student will carry the above listed medication at school. I also understand this student will be entirely responsible for the use of this medication and use of this medication will not be monitored by school personnel.

OTHER PERTINENT MEDICATION	DOSAGE	TIME	COMMON SIDE EFFECTS/SPECIAL INSTRUCTIONS

Physician's signature X Date / /

Physician (Printed Name) Phone

Clinic Fax

SPECIAL CONSIDERATIONS & PRECAUTIONS (regarding school activities, sports, field trips, etc.)

AUTHORIZATION FOR STAFF ADMINISTRATION OF MEDICATION

I give permission for the school nurse to consult with my child's physician concerning any questions that arise with regard to the listed medication or my child's medical condition. I understand that trained school personnel (e.g. classroom teacher, paraprofessionals, health office staff, office staff) will follow the Anaphylaxis Emergency Care Plan as completed by my child's physician, Licensed School Nurse, & myself.

Parent/Guardian signature Date / /

Licensed School Nurse signature Date / /

ANAPHYLAXIS EMERGENCY CARE PLAN

SELF-ADMINISTRATION OF MEDICATION

☐ Not Applicable

I hereby authorize my child to self-administer the above named medication during school as prescribed by the physician.

I have read the student agreement.

I understand my child will carry this medication at school and use will not be monitored by school personnel.

I understand that trained school personnel (e.g. classroom teacher, paraprofessionals, health office staff, office staff) will follow the Anaphylaxis Emergency Care Plan as completed by my child's physician, Licensed School Nurse, and myself should my child be unable to self-administer his/her medication.

Parent/Guardian signature _____ Date ___/___/___

STUDENT AGREEMENT

I AGREE TO:

- ☐ Follow my prescribing physician's medication orders.
- ☐ Use correct medication administration technique.
- ☐ Not allow anyone else to use my medication.
- ☐ Keep a supply of my medication with me in school and on field trips.
- ☐ Notify the school nurse or health office personnel if my epinephrine is administered and 911 will be called.
- ☐ Notify the school nurse of health office personnel if I have any exposure to allergy-causing food or substances or exhibit any symptoms of an allergic reaction.

Student signature _____ Date ___/___/___

The student has demonstrated knowledge about proper use of his/her medication (epinephrine administration device)

LSN signature _____ Date ___/___/___

SEIZURE EMERGENCY CARE PLAN

Date of Plan: / / This plan is valid for the current school year: 20 - 20

STUDENT INFORMATION

Name DOB / / Grade School

Significant medical history:

CONTACT INFORMATION

Parent/Guardian Phone Mobile:

Emergency Contact Phone Mobile:

Physician/Health Care Provider Preferred Hospital

SEIZURE INFORMATION

SEIZURE TYPE	LENGTH	FREQUENCY	DESCRIPTION

Seizure triggers or warning signs: Last seizure:

Student's response after a seizure:

BASIC FIRST AID: CARE & COMFORT

- **Stay calm and track time**
- **Keep child safe**
- **Do not restrain**
- **Do not put anything in the mouth**
- **Stay with child until fully conscious**
- **Record seizure in log**

For generalized seizure:

- **Protect head**
- **Keep airway open/ watch breathing**
- **Turn child on side**

Does student need to leave the classroom after a seizure?

☐ Yes ☐ No

If yes,describe the process for returning student to classroom:

SEIZURE EMERGENCY PROTOCOL

Check all that apply & clarify below

☐ Contact school nurse at: _____

☐ Call 911 if seizure lasts longer than: _____

☐ Notify parent or emergency contact

☐ Administer emergency medications as indicated below

☐ Notify doctor

☐ Other:

A SEIZURE IS GENERALLY CONSIDERED AN EMERGENCY WHEN:

- **Convulsive generalized seizure lasts longer than 5 minutes**
- **Student has repeated seizures without regaining consciousness**
- **Student is injured or has diabetes**
- **Student has a first-time seizure**
- **Student has breathing difficulties**
- **Student has a seizure in water**

PHYSICIAN'S AUTHORIZATION FOR EMERGENCY MEDICATION ADMINISTRATION

EMERGENCY MEDICATION	DOSAGE	TIME	COMMON SIDE EFFECTS/SPECIAL INSTRUCTIONS

Physician's signature X Date / /

Physician (printed name) Clinic Phone

TREATMENT PROTOCOL

If medications are to be given during school, an Authorization to Administer Medication form MUST be completed.

MEDICATION	DOSAGE	TIME OF DAY GIVEN	COMMON SIDE EFFECTS/SPECIAL INSTRUCTIONS

Does student have a Vagus Nerve Stimulator? ☐ Yes ☐ No

If yes, describe magnet use:

SPECIAL CONSIDERATIONS & PRECAUTIONS

(regarding school activities, sports, field trips, etc.)

AUTHORIZATION FOR STAFF ADMINISTRATION OF MEDICATION

I give permission for the school nurse to consult with my child's physician concerning any questions that arise with regard to the listed medication or my child's medical condition. I understand that trained school personnel (e.g. classroom teacher, paraprofessionals, health office staff, office staff) will follow the Seizure Emergency Care Plan as completed by my child's physician, Licensed School Nurse, and myself.

Parent/Guardian signature Date / /

Licensed School Nurse signature Date / /