



2025-2026

Student Enrollment Form

School: St. Anthony Community Center
[] Half Day Pre [] MWF am
[] MWF pm [] TTh am
[] TTh pm
[] All Day Pre

Start Date:

Student Last Name First Name (as on birth certificate) Middle Name

Birth Date Gender [] Male [] Female Age Resident District if not St. Anthony New Brighton School District

Date completing this form:

Country of birth, if born outside of the USA: Date of Entry to USA:

Does this child identify as a "military-connected youth?"
[] Yes [] No **A "military-connected youth" means having an immediate family member, including a parent or sibling, who is currently in the armed forces either as a reservist or an active duty or has recently retired from the armed forces.
Has this child had a parent serve in active military duty in the last year? [] Yes [] No

Is this child a ward of the state? [] Yes [] No
Is this child in foster care? [] Yes [] No
Is this child homeless? [] Yes [] No
To meet the state standards for homelessness, any of these may apply. - Staying in a shelter, sharing housing, or temporarily living in a motel or hotel due to loss of housing or economic hardship - Living in a car, campground or other inadequate accommodation - Living alone as a minor student without parent or guardian

What language is spoken at home?

What is the parents' preferred language for school communication?

Has your child had early childhood screening through a Minnesota School District? [] Yes [] No
If yes, through what district?

Does your child have an I.E.P. (Individualized Education Plan) or an I.F.S.P (Individual Family Service plan)?
[] Yes [] No If yes, please submit a copy of the plan to the Preschool Office.

Has student been enrolled in St. Anthony New Brighton School District programs in the past? [] Yes [] No
If yes, through what programs?

Empty box for additional information

It is the St. Anthony New Brighton School District's policy to provide equal education opportunity for all students and to provide equal employment opportunity for all employees. The district does not discriminate in admission, treatment, employment or access to its programs or activities. In addition, the School District does not unlawfully discriminate on the basis of race, color, creed, religion, national origin, sex, marital status, parental status, status with regard to public assistance, disability, sexual orientation or age.



SECTION I

Household #1: School communication will be sent to this address.
 Student lives here full time (please sign below) part time or not at all (please go to Section II)

Address	City	State	Zip	Home Phone
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Household Adult 1		Relationship to Student	Phones	E-Mail Address
Last Name	First Name	Gender	Cell	
		<input type="radio"/> Male <input type="radio"/> Female	Work	

Household Adult 2		Relationship to Student	Phones	E-Mail Address
Last Name	First Name	Gender	Cell	
		<input type="radio"/> Male <input type="radio"/> Female	Work	

Other Children in Primary Household:					
Last Name	First Name	Gender	Relationship to Student	Birth Date	School Attending
		<input type="radio"/> Male <input type="radio"/> Female			
		<input type="radio"/> Male <input type="radio"/> Female			
		<input type="radio"/> Male <input type="radio"/> Female			
		<input type="radio"/> Male <input type="radio"/> Female			
		<input type="radio"/> Male <input type="radio"/> Female			

My child lives with: _____ Custody Arrangements: _____

SECTION II

Household #2, if applicable. Check here if school communication is also to be sent to this address.
 Student lives here full time part time not at all

Address	City	State	Zip	Home Phone
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Household Adult 1		Relationship to Student	Phones	E-Mail Address
Last Name	First Name	Gender	Cell	
		<input type="radio"/> Male <input type="radio"/> Female	Work	

Household Adult 2		Relationship to Student	Phones	E-Mail Address
Last Name	First Name	Gender	Cell	
		<input type="radio"/> Male <input type="radio"/> Female	Work	

Other Children in Household:				
Last Name	First Name	Gender	Relationship to Student	Birth Date
		<input type="radio"/> Male <input type="radio"/> Female		
		<input type="radio"/> Male <input type="radio"/> Female		
		<input type="radio"/> Male <input type="radio"/> Female		
		<input type="radio"/> Male <input type="radio"/> Female		

Parent/Guardian Signature:	Date:
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Child's Name (Please print): _____ Date of Birth: _____
 Nickname: _____

PLEASE PRINT:

Parent/Guardian Name	Phone	Notify using phone or email?	E-Mail Address

The following person(s) are ALSO allowed to pick up my child from Preschool:

Name	Phone

My signature below indicates my authorization for the above-named persons to pick up my child from Preschool.

The following person(s) are NOT allowed to pick up my child from Preschool:

Name	Is this a non-custodial parent?	Is there a current restraining order in effect?

Please note: Copies of restraining orders/court orders must be on file in the school office.

Signature of Parent/Guardian:

Date:

- Half Day Pre:
 - MWF am
 - MWF pm
 - TTh am
 - TTh pm
- All Day Pre

Student Last Name

First Name

Nick Name

Any special medical needs/conditions/allergies:

Triggers to allergens:

Techniques to avoid exposure to allergens:

Allergy symptoms:

How to respond to reaction (medications/dosages):

What are your child's eating habits:

What are your child's toileting needs/words:

Suggestions for staff to comfort your child (has he/she expressed fears about coming to preschool?)

How does your child communicate (i.e., point, with words, short sentences)?

Describe your child's previous group experiences (full day care, home day care, etc.):

How does your child separate from parent(s)/family?

Describe your child's temperament/strengths:

What skills would you like to see your child develop while attending our program?

Any additional information that would be helpful in getting to know your child?

EXPLANATION OF PRIVATE INFORMATION REQUESTED ON THIS FORM

In accordance with the Federal Data Privacy Act of 1974 and the State of Minnesota Privacy Law, you are not required to provide the information noted with an asterisk (*). There will be no adverse affect on you or your student if you do not choose to provide it. However, your cooperation in providing this information will ensure its accuracy and help to facilitate equitable educational opportunities for all students. Be assured that we will use the information in a manner that respects the privacy of our students and families.

***Home Primary Language:** In order to assist school districts to provide equal opportunity for a meaningful education to all students, Minnesota law requires that schools count and report the primary language of their students.

***Racial/Ethnic Background of Student:** This information is needed to comply with state and federal reporting requirements relating to equity in education. Your cooperation in providing this information will ensure that we have accurate data on your child. In addition to meeting our reporting responsibilities, the District may also use this data to analyze student achievement across a range of demographic and programmatic characteristics in order to better meet the learning needs of our students. On the front of this form, please select all the groups with which you and/or your student most identify.

- 1) Hispanic– A person of Mexican, Puerto-Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.
- 2) American Indian or Alaskan Native – A person having origins in any of the original peoples of North and South America and who maintains cultural identification through tribal affiliation or community recognition.
- 3) Asian – A person having origins in any of the original peoples of the Far East, SE Asia, or the Indian subcontinent. This area includes, for example, China, India, Japan and Korea. Philippine Islands and Samoa.
- 4) Black or African American– A person having origins in any of the Black racial groups of Africa.
- 5) Native Hawaiian or Other Pacific Islander - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- 6) White – A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Ethnic and Racial Demographic Designation Form

Student's First Name: _____ Middle Name/Initial: _____ Last Name: _____

Date of Birth: _____ District: _____ School: _____

Schools are required to report ethnicity and race to the state and to the U.S. Department of Education. Because of recent changes to Minnesota state law, Minnesota disaggregates each category into detailed groups to further represent our student populations. Parents or guardians are not required to answer the federal questions (**in bold**) for their children. If you choose not to answer the federal questions (**in bold**), federal law requires schools to choose for you. This is a last resort—we prefer if parents or guardians complete the form. State questions are labeled as “Optional” and schools will not fill in this information for you.

This information helps improve teaching and learning for everyone and helps us accurately identify and advocate for students currently underserved. The information this form collects is considered private information. You can review the privacy notice to learn more about the purpose of collecting this information, how it will be used and not used, and how the detailed groups were identified. The privacy notice can be found in our [Frequently Asked Questions: Ethnic and Racial Designation Form](#).

Is the student Hispanic/Latino as defined by the federal government? The federal definition includes persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.¹

[You must select “yes” or “no” to this question.]

Yes *[If yes, go to Question A.]*

No *[If no, go to Question 1.]*

Optional Question A: If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

- | | | | |
|--|---------------------------------------|--|--|
| <input type="checkbox"/> Decline to indicate | <input type="checkbox"/> Guatemalan | <input type="checkbox"/> Salvadoran | <input type="checkbox"/> Other Hispanic/Latino |
| <input type="checkbox"/> Colombian | <input type="checkbox"/> Mexican | <input type="checkbox"/> Spaniard/Spanish/
Spanish-American | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Ecuadorian | <input type="checkbox"/> Puerto Rican | | |

Go to Question 1.

[Select “yes” to at least one of the Questions (1-6) below.]

Question 1: Does the student identify as American Indian or Alaska Native as defined by the state of Minnesota? The state of Minnesota definition includes persons having origins in any of the original peoples of North America who maintain cultural identification through tribal affiliation or community recognition. [This question is needed to calculate state aid/funding.]

Yes *[If yes, go to Question 1a.]*

No *[If no, go to Question 2.]*

Optional Question 1a: If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

- | | | |
|--|--|---|
| <input type="checkbox"/> Decline to indicate | <input type="checkbox"/> Cherokee | <input type="checkbox"/> Other North American Indian Tribal Affiliation |
| <input type="checkbox"/> Anishinaabe/Ojibwe | <input type="checkbox"/> Dakota/Lakota | <input type="checkbox"/> Unknown |

Go to Question 2.

¹Federal Register, Vol. 72, No. 202/Friday, October 19, 2007/Notices/59274

Question 2. Is the student American Indian from South or Central America?

Yes [Go to Question 3.]

No [Go to Question 3.]

Question 3. Is the student Asian as defined by the federal government? The federal definition includes persons 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.¹

Yes [If yes, go to Question 3a.]

No [If no, go to Question 4.]

Optional Question 3a. If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

Decline to indicate

Chinese

Karen

Other Asian

Asian Indian

Filipino

Korean

Unknown

Burmese

Hmong

Vietnamese

Go to Question 4.

Question 4. Is the student black or African American as defined by the federal government? The federal definition includes persons having origins in any of the black racial groups of Africa.¹

Yes [If yes, go to Question 4a.]

No [If no, go to Question 5.]

Optional Question 4a. If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

Decline to indicate

Ethiopian-Other

Somali

African-American

Liberian

Other black

Ethiopian-Oromo

Nigerian

Unknown

Go to Question 5.

Question 5. Is the student Native Hawaiian or Other Pacific Islander as defined by the federal government? The federal definition includes persons having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.¹

Yes [Go to Question 6.]

No [Go to Question 6.]

Question 6. Is the student white as defined by the federal government? The federal definition includes persons having origins in any of the original peoples of Europe, the Middle East, or North Africa.¹

Yes

No

Parent(s)/Guardian Name _____ Date _____

Parent(s)/Guardian Signature _____

Print/Save

Health Care Summary For Child Care Attendance

FORM H-300
Fax to 612 706 1165

(to be completed by physician/nurse practitioner)

Program Name: _____	Date of enrollment: ___/___/___			
Child's Name: _____	Date of Birth: ___/___/___			
Address: _____				
Street	City	State	Zip	Phone No.
Parent/Guardian: _____				

Date of last physical exam: _____

Is the child up-to-date on their immunizations? Yes No

If no, plan for bringing the child up-to-date _____

Copy of immunizations attached and signed by health care provider? Yes No

Allergies: _____

Does the child have any important health concerns that you are following them for? _____

Does the child have any important health concerns that are followed by another source of health care? (if so, please give name of provider and condition requiring attention) _____

Does the child have any special needs that require accommodation by the provider? _____

Does the child have any conditions that may result in an emergency? _____

Does the child have any activity restrictions? _____

Is a modified diet necessary? _____

Does the child require a certain sleep position? _____

What is the status of the child's Vision: _____

Hearing: _____ Speech: _____

Is there any other information that would be helpful in a group care setting? _____

Primary health care providers name: _____

Clinic Name: _____ Phone #: () _____

Address: _____
Street City State Zip

Signature of Health Care Provider: _____
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	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>Haemophilus influenzae</i> type b (Hib)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pneumococcal (PCV)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Polio	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Measles, Mumps, Rubella (MMR)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Chickenpox (varicella)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hepatitis A	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Tetanus, Diphtheria, Pertussis (Tdap)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Meningococcal (MCV4)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Minnesota law requires children enrolled in child care, early childhood education, or school to be immunized against certain diseases, unless the child is medically or non-medically exempt.

Instructions for parent or guardian:

- Fill out the dates in chronological order even if your child received a vaccine outside of the age/grade category that the box is in. Depending on the age of your child, they may not have received all vaccines; some boxes will be blank.
 - If you have a copy of your child's immunization history, you can attach a copy of it instead of completing the front of this form.
 - Your doctor or clinic can provide a copy of your child's immunization history. If you are missing or need information about your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-3980 or 800-657-3970.
- Sign or get the signatures needed for the back of this form.
 - Document medical and/or non-medical exemptions in section 1.
 - Verify history of chickenpox (varicella) disease in section 2.
 - Provide consent to share immunization information (optional) in section 3.

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		
<i>Haemophilus influenzae</i> 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*)

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.

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 _____

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)