NORTHSIDE
CHRISTIAN SCHOOL

804 131st Ave. NE, Blaine, MN 55434; 763-755-3993; e-mail: office@northsidemn.org

NCS Pre K Parent Packet for
Pre-K First Day
Parent Signature for the Completion of Reading and Documents

Northside would like to welcome your family to the Pre-K program. The Minnesota Department of Human Services (MDHS) for Licensing and Northside Christian School Administration to complete all attached documents. This packet is to be copied, completed and given to the NCS office **before your child may enter the classroom**. The final due date to complete NCS Pre-K First Day Documents for a child enrolled is five days before their first day of class.

By completing these documents, you do not need to duplicate any forms on TADS

Authorization for Reading the policies **posted on the web-site** for familiarity/understanding the Pre-K program

- **Preschool Handbook**
- NCS **Yearly Calenda**r
- MN Department of Human Services/NCS **Child Care Emergency Plan**
- **Maltreatment of Minors** Mandated Reporting Policy for DHS Licensed Programs
- NCS **Lunch Guidelines** / Cold Lunch Ideas
- Policy for **After Care**

Copy the following for your child's file (forms may be scanned and emailed to office@northsidemn.org)

- Copy of an official **Birth Certificate**
- Current **immunizations document**
- If parent chooses to **exempt from** school immunization the parent must fill out the back of the 'Student Immunization Form' and have it notarized by a Notary

Required Parent forms that must be complete with signature and a paper copy placed in the child's school file.

- **Minnesota Preschool Health Care Summary** copied and filled out by child's physician
- **Individualized Personal Health Care Plan** – Part C must be filled out by the child's physician or the parent if there are no orders by the physician.
- **Emergency Contact Form** - 2 primary and 2 secondary
- **Media and Photo release authorization form**
- **NCS After Care Program Request Form**

I the parent or guardian have truthfully read and understand each of the above documents and have filled out each of the above forms to the best of my ability. I have given NCS Office the required completed forms before my child's first day of class. I agree to the terms and guidelines as set by NCS administration and school board.

Print parent or guardian's name: _____

Parent or Guardian's signature: _____ Date: _____

NCS Preschool Director's signature: _____ Date: _____

4/1/23

NORTHSIDE
CHRISTIAN SCHOOL

Minnesota Prekindergarten Health Care Summary

Child's Name: _____ Date of Birth: _____

Parent name: _____ Phone: _____

Address: _____ Date of Enrollment: _____

(This form is in addition to the immunization form/report)

Completed by Family Physician

(Form required by the state of Minnesota)

Date of last physical examination _____. How long have you been seeing this child? _____

How frequently do you see this child when he/she id not ill? _____

Does this child have any allergies – if the answer is yes, please fill out the 'Individualized Personal Health Care Plan (including allergies to medications)? _____

Is a modified diet necessary? _____

Is any condition present that might result in any emergency? _____

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

Hearing _____

Speech _____

List the important health problems: Followed by you _____

Followed by other med source (name) _____

Requires Special attention at a center _____

Other information that is helpful to the child's program _____

Physician's address or clinic name _____

Physician's printed name: _____

Physician's signature _____ Phone _____

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4/1/23

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 understand 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)

NORTHSIDE CHRISTIAN SCHOOL

Individualized Child Care Program Plan (ICCPP) – Medical or Learning needs as mandated by licensing

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Part A: Family Information – by parent

Child's Name: _____ Date of Birth: _____

Parent name: _____ Phone: _____

2ne name for emergency: _____ Phone: _____

Clinic & Physician's Name: _____ Phone: _____

Clinic & Dentist's Name: _____ Phone: _____

Other Specialist Name: _____ Phone: _____

Part B: Medical History: Sensitivities and Allergies – by physician or parent

Check all that applies and give an explanation of the following:

- Any professional health/academic diagnosis (attach the report):
- Health care conditions/treatments/procedures:
- Life-threatening conditions:
- Vision or hearing
- Allergies (plants, animals, food, molds, drugs, bees, insects, lotions, sprays, other:
- Asthma action Plan

List the triggers / symptoms or **avoidance techniques**: (add phrase 'No Additional Triggers' at the end)

How quickly do the signs/symptoms appear after exposure?

List any special accommodations as required by the physician:

Part C: Treatment for medical needs – by Physician and Parent

Northside does not have a licensed nurse on staff; therefore, the administration requests that if possible all medication be administered by the child's parent. If it is necessary for medication (both prescription and non-prescription) to be given during the school day by the classroom teacher, please send with your child.

- The Individualized Personal Health Care Plan filled out by the parent
- The prescription or original bottle with the child's name on the bottle. This bottle is readily available to staff and is stored out of reach from any child.
- **The following filled out by the child's physician or parent if no physician's orders:**

I _____ (Physicians name printed) have prescribed the following medication and request the dosages be given during school hours:

Name of Medication_____ Dosage to be given _____

How is the medication to be stored? _____

Unit dose (strength provided _____ Number of unit doses (e.g. tablet, liquid) _____

Time to be given_____ How to be given _____

For treatment of _____

Possible side effects _____

Possible interventions that may be required _____

Special instructions (include an attachment if need more space) _____

_____

_____

_____

Last date to be given _____

Physician's address or clinic name _____

Physician's printed name: _____

Physician's signature _____ Phone _____

Part D: Other Special Needs

Write a brief statement listing the need and the specialist's diagnosis:

List areas of Developmental concerns:

List any services the child has received or is receiving outside of the school:

List any specifications by the specialist for indoor/outdoor activities:

Part E: Parental request for administration of medication and release authorization

Only when a medication is prescribed to be taken during school hours will a child be given medication at school. I request this medication be given as prescribed and the above requested information be released from the physician to the school.

I understand the information given will be shared with appropriate school staff to provide for the health and safety of my child. If either I or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize and direct school staff to send my child to the most easily accessible hospital or physician. I understand I will assume full responsibility for payment of any transport or emergency medical services rendered.

Parent's printed name: _____

Parent/Guardian Signature _____

Date _____

Part F: All staff working with the child have been informed and trained on any specific needs as directed by any specialist:

Director's signature _____

Lead Teacher's signature _____

Teacher's Aid Signature _____

Other aid signature _____

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Preschool Emergency Contact Information

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Child's Name: _____ Date of Birth: _____

Child's Address_____

Parent name _____

Parent Signature _____ Date _____

The Minnesota Department of Health Services for Licensing requires all parents to provide the teacher with two primary and two secondary contacts to be placed in the classroom in case of an emergency. Please fill out the following in descending order of who you would like to have contacted: (This form is in addition to the emergency information provided on TADS)

Two Primary Contacts

1. Name: _____(relation)_____

   Address: _____

   Preferred phone number _____ Alternate phone number _____

2. Name: _____(relation)_____

   Address: _____

   Preferred phone number _____ Alternate phone number _____

Two Secondary Contacts / Alternate People Authorized for Drop-off or Pick-up

1. Name: _____(relation)_____

   Address: _____

   Preferred phone number _____ Alternate phone number _____

2. Name: _____(relation)_____

   Address: _____

   Preferred phone number _____ Alternate phone number _____

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Pre K
NCS and Classroom Media/Photo Release

Dear Parents/Guardians

Northside's staff and volunteers, representatives of the news media and others occasionally photograph and audio and/or video record Northside's students. The photos, audiotapes and videotapes may be used in school and community newsletters, e-newsletters, newspapers, activity programs, yearbooks, brochures, educational videos, podcasts, websites, social media sites and television, and for other appropriate school-related uses.

Parents/guardians may choose to limit the use of their child's photo. Please initial one of the restriction options:

_____ **No Restriction:** My child's photo will be taken and/or my child may be videotaped or audiotape for all school purposes as described above.

_____ **Partial Restriction:** My child's photo will be taken and used only for the school yearbook (including individual and group photos for class and activities), and for school identification records.

Read and initial the classroom use only:

_____ **Classroom Photo Release:** The teacher has my permission for pictures of my child to be taken by the teacher throughout the school year for in-house purposes only. Examples of pictures taken: first day of school, cubby pictures, special events, and pictures of my child during daily school activities, etc. These photos will not be used for any other purpose and will not be released on social media.

Note to Parents: All students' photographs are taken and used for internal school identification purposes.
If you have marked "Partial Restriction," the school will take reasonable steps to prevent your child from being photographed or audio/video recorded, however the school cannot guarantee your child will not be photographed or audio/video recorded in situations such as school assemblies and chapel, walking through school hallways, and other situations where there are large numbers of students present. If you require additional restrictions for your child's photo, please contact Vice Principal, Marjean Halverson at 763-755-3993. This document will be kept in your students' cumulative file.
Thank You.

Print Student Name: _____

Print Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Teacher Signature: _____ Date: _____

NORTHSIDE
CHRISTIAN SCHOOL

NCS
AFTER CARE PROGRAM

Required form for all
Pre- K Students

School Year _____

Child's Name_____
Last First Middle

Grade_____ Birth date_____

Parent/Guardian (please print) _____

Address_____
Street City State/Zip

Telephone Numbers: Home_____

Work_____

Cell_____

Parent/Guardian's signature for having read and understand NCS Policy for After Care _____

****

Sign in: In case of an emergency the parent can call Northside office 763-755-3993 for an occasional use of the program.

- If any **full day** child is not picked up by 2:05 they will be signed in by the teacher to the After Care Program and the family will be charged per hour. The parent will be contacted by the Program Director for how to contact him/her when the parent arrives for pick-up of the child.

Cost: Daily rate is $12.00 per hour (hours 2:05 – 4:15 pm)

Day(s) of the week for students who use the program on a regular basis: Indicate the day(s) of the week you will be using

____Monday ____ Tuesday Wednesday Thursday Friday

The After Care Teacher will complete a daily log in sheet for your child with the times and your signature. You will receive monthly billing on your TADS account based on the number of hours that your child(ren) attended After Care.

4/1/23