ST. MARY'S
CATHOLIC SCHOOL - MORRIS, MN

REGISTRATION FORM

p.(320)589-1704
www.stmarysmorris.com

The following information is needed for school records. All information given will be considered confidential. Please call if there is a change in any of this information at any time during the year. PLEASE PRINT

STUDENT INFORMATION

Student's Name _____ Sex: ☐ Male ☐ Female
Last First Middle

Grade: _____ Age: _____ Birthdate: _____ Religion: ☐ Catholic ☐ Other

Ethnicity: ☐ White ☐ Asian ☐ Black ☐ Hispanic ☐ Am. Indian

Place of Birth: _____
City County State

Home Address: _____ Home Telephone: _____
Street City State Zip

PARENT/GUARDIAN INFORMATION

Parent #1 Name: _____ Relationship: ☐ Parent ☐ Grandparent ☐ Guardian

E-Mail Address: _____ Cell Phone: _____

Place of Employment: _____ Work Phone: _____

Parent #2 Name: _____ Relationship: ☐ Parent ☐ Grandparent ☐ Guardian

E-Mail Address: _____ Cell Phone: _____

Place of Employment: _____ Work Phone: _____

Marital Status: ☐ Married ☐ Single
Student Lives With: ☐ Father ☐ Mother ☐ Both Parents ☐ Guardian

FAMILY INFORMATION

Number of children in Family: _____ Rank in family: _____

Name: _____ Age: _____ Grade: _____ St. Mary's Student? ☐ Yes ☐ No
Name: _____ Age: _____ Grade: _____ St. Mary's Student? ☐ Yes ☐ No
Name: _____ Age: _____ Grade: _____ St. Mary's Student? ☐ Yes ☐ No
Name: _____ Age: _____ Grade: _____ St. Mary's Student? ☐ Yes ☐ No

Family doctor to call in case of emergency or illness: _____ Phone: _____

Emergency Contacts:
#1: _____ Phone: _____ Address: _____
#2: _____ Phone: _____ Address: _____

Will bus transportation be required? ☐ Yes ☐ No

_____ _____ _____
Parent#1 Signature Parent #2 Signature Date

In accordance with federal law this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability.

Family and Social Background

This form will be shared with your child's teacher.

Members of household and their relationship to child:

_____

_____

Marital status of Parents: ☐married ☐single parent ☐separated ☐divorced
☐other:_____

Custody or visiting arrangements: _____

If child is adopted, age of adoption_____ Does your child know about it? _____

Does this child have any allergies (including allergies to medications)? _____

Describe your child's eating habits? Is a modified diet necessary?

_____

Provide information about your child's toileting habits: _____

Has your child previously attended a childcare center or daycare? _____

How long? _____ Was it a successful placement? _____
Comments:

Please list the names and telephone numbers of any persons authorized to take the child from school

Name: _____ Phone _____

Name: _____ Phone _____

Name: _____ Phone _____

Name: _____ Phone _____

Please list the persons to be contacted if a parent cannot be reached in an emergency or when there is an injury requiring medical attention

Name: _____ Phone _____
Address
_____

Name: _____ Phone _____
Address
_____

If your child has any emotional, behavioral, or medical concerns that we should be aware of please explain below.

Child's Schedule at school – please check the days/times your child will be at school:

- ☐ 5 Full Days – Monday/Tuesday/Wednesday/Thursday/Friday
- ☐ 3 Full Days – Monday/Wednesday/Friday
- ☐ 2 Full Days – Tuesday/Thursday

- ☐ After-School care (3:05-5:45pm)

_____ _____
Parent/Guardian Signature Date

Non-Prescribed Medication Authorization

The following non-prescribed items: diapering products, sunscreen lotions, teething gel and insect repellants will be given with parental permission and according to manufacturer's instructions unless there are written instructions provided by a licensed physician or dentist.

The following is by Director Exception only: Child will be given prescribed or non-prescribed oral or surface medication with physician permission. Medication must be in its original container and have a legible label with the child's name and current prescription information. Non-prescribed items (cold medicine or Tylenol) not mentioned above must be accompanied by a doctors note. The administration of medication is recorded and the record is approved by the child's parent. Any expired or unused portion will be returned to the child's parent or destroyed.

I hereby authorize the staff of St. Mary's School to administer the checked below listed medications. I understand that no other prescribed or non-prescribed medications will be given without physician's written permission.

_____ Teething Gel (oral gel)
_____ Sunscreen Lotions
_____ Diapering Products
_____ Insect Spray

Signature of parent or guardian Date

Field Trip Authorization

I hereby give my permission for my child to go on impromptu walking field trips in the neighborhood. This includes walks around the blocks in the adjoining neighborhood. I understand that I will be notified of field trips for farther distances through a written permission form.

Signature of parent or guardian Date

Parent Handbook and Program Plan

By signing this form you are acknowledging that you have received, read, had an opportunity to ask questions, understand, and agree to abide by our Parent Handbook and Program Plan.

Signature of parent or guardian Date

Emergency Authorization

I authorize St. Mary's School to act on my behalf in the case of an emergency and provide emergency care and treatment.

Signature of parent or guardian Date

Health Care Summary

Completed by a healthcare provider

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 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 School

Other information helpful to the school:

_____

_____

Child's source of regular medical care:

Name: _____ Phone _____

Address: _____

Dental Care:

Name: _____ Phone _____

Address: _____

Emergency Medical Care:

Name: _____ Phone _____

Address: _____

Emergency Dental Care:

Name: _____ Phone _____

Address: _____

Signature of Health Source _____ **Date** _____

ST. MARY'S
CATHOLIC SCHOOL - MORRIS, MN

Publicity Release

Throughout the school year, St. Mary's School will conduct activities that may be publicized through local and national news media. These activities may include interview sessions with news reporters, photographs of individual students or groups of students for newspapers or various school publications including newsletters, calendars, brochures, the use of student photos on the St. Mary's Website, Facebook, church bulletin and video taping for news programs and school promotional videos.

Please check one of the two statements below. Sign and return this document to school.

___ I grant permission for my name, our child(ren)'s name, voice and photographic likeness to be used by St. Mary's School personnel, publicists, or reporters, journalists or photographers employed by the news media.

___ I do not give permission for my name, my child(ren)'s name, voice and photographic likeness to be used by St. Mary's School personnel, publicists or reporters, journalists, or photographers employed by the news media.

Child(ren)'s Name(s): _____

Signed: _____
Parent/Guardian

Date: _____

ST. MARY'S CATHOLIC SCHOOL 311 COLORADO AVE., MORRIS, MN 56267
PHONE-(320) 589-1704 FAX-(320)589-1703

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)