Hopkins School District
Health Services

# Health Information Form

Child's Name:________________________________________________________________
(Last) (First) (Middle)
Date of Birth:______________ School:_____________________ Grade/Program:________________

**Health or Disability Concerns**: **Please indicate if your child has any of these concerns and explain:**

☐ **No Health Concerns**
☐ Allergic Reactions to be aware of at school (to what?) ________________________________________
(Describe reaction) _________________________________________________ ☐ Medication (see below)
If your child will require an epi-pen, you will need to complete a consent form, signed by your pediatrician.
☐ Attention Disorder: ☐ ADD ☐ ADHD ☐ Medication (see below) ☐ Does not take medication for ADD / ADHD
☐ Asthma Known Triggers:___________________________________________ ☐Medication (see below)
☐ Autism Spectrum Disorder , age of diagnosis __________
☐ Diabetes: ☐ Type 1 ☐ Type 2 ☐Insulin Injections ☐Insulin Pump ☐Oral medication
☐ Heart Problem (describe) ________________________________________________________________
☐ Hearing Loss: ☐ right ear ☐ left ear ☐ Hearing Aids: ☐ right ear ☐left ear
☐ Vision: ☐ Wears glasses /contacts ☐ wears in classroom only ☐ lost / broken
☐ Neurological_____________________________________________________________________________
☐ Seizures: Type: ________________________________________ Date of last seizure: ______________
☐ Recent surgery or hospitalization: Explain____________________________________________________
☐ Mental Health concerns _______________________________________________________________
☐ Other health concerns or additional health information: ______________________________________
_____________________________________________________________________________________
**Emergencies:** Does your child have a health concern that could result in an emergency? ☐YES ☐NO
If yes, please describe:____________________________________________________________________

**Medications:** List All medications that your child takes every day or when needed. * Consent forms are required yearly for ALL medications administered at school. Forms are available on-line or in nurses offices.

| Name of Medication | Purpose | Dose | How Often Taken |
|---|---|---|---|
| | | | |
| | | | |

Does your child need a special diet? ☐YES ☐ NO If yes, please describe: __________________________

Pre-School and Kindergarten: Has your child had an Early Childhood Screening? ☐ YES ☐ NO
If Yes, location and date of screening:_____________________________________________________

Do you have any comments or information that would help us care for your child's health needs while at school?
_____________________________________________________________________________________

The above information is helpful in establishing a comprehensive picture of your child's health and safety needs while at school. The information on this form will be entered into the district's secure electronic data system and considered confidential. There will be no consequences for not providing the information. However, it may result in an incomplete health and safety plan for your child. The information you provide will be shared only with staff in the school district whose jobs require access to this information to ensure your child's safety and school success. (MS Section 13.04, Subdivision 2)

**PARENT/GUARDIAN SIGNATURE:** _________________________________**DATE**:______________
Primary Phone: _________________________________
Emergency Contact/ Authorized to Pick Up Student and Phone Number: ______________________________

# Early Childhood Immunization Form

*Must be on file **before** a child attends any early childhood programs**

Name ______________________________________

Birthdate ______________________________________

Date of Enrollment ______________________________

*Early childhood programs are defined as programs that provide instructional or other services to support children's learning and development and:
- Serve children from birth to kindergarten.
- Meet at least once a week for at least six weeks or more during the year.

This includes but not limited to early childhood family education (ECFE), early childhood special education (ECSE), school readiness programs, and other public and private preschool and pre-kindergarten programs.

Minnesota law requires children enrolled in early education programs to be immunized against certain diseases or file a legal medical or conscientious exemption.

**Parent/Guardian:**
You may attach a copy of the child's immunization history to this form OR enter the MONTH, DAY, and YEAR for all vaccines your child received. Enter MED to indicate vaccines that are medically contraindicated including a history of disease, or laboratory evidence of immunity and CO for vaccines that are contrary to parent or guardian's conscientiously held beliefs.

Sign or obtain appropriate signatures on reverse. Complete section 1A or 1B to certify immunization status and section 2A to document medical exemptions (including a history of varicella disease) and 2B to document a conscientious exemption.

Additionally, if a parent or guardian would like to give permission to the early education program to share their child's immunization record with Minnesota's immunization information system, they may sign section 3 (optional).

For updated copies of your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-5503 or 800-657-3970.

| **Type of Vaccine** DO NOT USE (✓) or (×) | **1st Dose Mo/Day/Yr** | **2nd Dose Mo/Day/Yr** | **3rd Dose Mo/Day/Yr** | **4th Dose Mo/Day/Yr** | **5th Dose Mo/Day/Yr** |
|---|---|---|---|---|---|
| **Required** (The shaded boxes indicate doses that are not routinely given; however, if your child has received them, please write the date in the shaded box.) | | | | | |
| **Diphtheria, Tetanus, and Pertussis** (DTaP, DTP)<br>• 3 doses during 1st year *(at 2-month intervals)*<br>• 4th dose at 12-18 months<br>• 5th dose at 4-6 years<br>*Indicate vaccine type: DTaP or DTP* | | | | 5th dose not required if 4th dose was given on or after the 4th birthday | |
| **Polio** (IPV, OPV)<br>• 2 doses in the first year<br>• 3rd dose by 18 months<br>• 4th dose at 4-6 years | | | 4th dose not required if 3rd dose was given on or after the 4th birthday | | |
| **Measles, Mumps, and Rubella** (MMR)<br>• Required for children 15 months and older<br>• 1st dose on or after 1st birthday<br>• 2nd dose at 4-6 years | | | | | |
| ***Haemophilus influenzae* type b (Hib)**<br>• 2-3 doses in the first year<br>• 1 dose required after 12 months or older<br>• For unvaccinated children 15-59 months, 1 dose is required<br>• Not required for children 5 years or older | | | | | |
| **Varicella** (chickenpox)<br>• Required for children 15 months and older<br>• 1st dose on or after 1st birthday<br>• 2nd dose at 4-6 years | | | | | |
| **Pneumococcal Conjugate Vaccine (PCV)**<br>• Required for children age 2 - 24 months<br>• 3 doses in the first year<br>• 4th dose after 12 months<br>• At least 1 dose is recommended for children age 24-59 months in child care | | | | | |
| **Hepatitis B** (hep B)<br>• 2-3 doses in the first year<br>• 3rd dose (final dose) by 18 months | | | | | |
| **Hepatitis A** (hep A)<br>• 2 doses separated by 6 months for children 12 months and older | | | | | |
| **Recommended** | | | | | |
| **Rotavirus** (2-3 doses between 2 and 6 months) | | | | | |
| **Influenza** (annually for children 6 months or older) | | | | | |

Name ______________________________________________

**Instructions, please complete:**
*Box 1 to certify the child's immunization status*
*Box 2 to file an exemption (medical or concientious)*
*Box 3 to provide consent to share immunization information (optional)*

## 1. Certify Immunization Status. 
Complete A or B to indicate child's immunization status.

**A. Children who are 15 months or older:**
For children who are 15 months or older and who have received all the immunizations required by law for early childhood programs:

I certify that the above-named child is at least 15 months of age and has completed the immunizations which are required by law for child care.

______________________________
Signature of Parent / Guardian OR Physician / Nurse Practitioner / Physician Assistant / Public Clinic

_______________ Date

**B. Children who are younger than 15 months:**
For children who are younger than 15 months OR have not received all required immunizations:

I certify that the above-named child has received the immunizations indicated. In order to remain enrolled this child must receive all required vaccines within 18 months from initial enrollment date. The dates on which the remaining doses are to be given are:

______________________________
Signature of Physician / Nurse Practitioner / Physician Assistant / Public Clinic

_______________ Date

## 2. Exemptions to Immunization Law. 
Complete A and/or B to indicate type of exemption.

**A. Medical exemption:**
No child is required to receive an immunization if they have a medical contraindication, history of disease, or laboratory evidence of immunity. For a child to receive a medical exemption, a physician, nurse practitioner, or physician assistant must sign this statement:

I certify the immunization(s) listed below are contraindicated for medical reasons, laboratory evidence of immunity, or that adequate immunity exists due to a history of disease that was laboratory confirmed (for varicella disease see * below). List exempted immunization(s):

______________________________
Signature of physician/nurse practitioner/physician assistant

_______________ Date

*History of varicella disease only. In the case of varicella disease, it was medically diagnosed or adequately described to me by the parent to indicate past varicella infection in ___________ (year)

______________________________
Signature of physician/nurse practitioner/physician assistant (If disease occured before September 2010, a parent can sign.)

**B. Conscientious exemption:**
No child is required to have an immunization that is contrary to the conscientiously held beliefs of his/her parent or guardian. However, not following vaccine recommendations may endanger the health or life of the child or others they come in contact with. In a disease outbreak, children who are not vaccinated may be excluded in order to protect them and others. To receive an exemption to vaccination, a parent or legal guardian must complete and sign the following statement and have it notarized:

I certify by notarization that it is contrary to my conscientiously held beliefs for my child to receive the following vaccine(s):

______________________________
Signature of parent or legal guardian

_______________ Date

Subscribed and sworn to before me this:
_______ day of ______________________ 20______

______________________________
Signature of notary (A copy of the notarized statement will be forwarded to the commissioner of health.)

## 3. Parental/Guardian Consent to Share Immunization Information (optional):
Your child's early childhood program is asking your permission to share your child's immunization documentation with MIIC, Minnesota's immunization information system, to help better protect children from disease and allow easier access for you to retrieve your child's immunization record. You are not required to sign this consent; it is voluntary. In addition, all the information you provide is legally classified as private data and can only be released to those legally authorized to receive it under Minnesota law.

I agree to allow early childhood program personnel to share my child's immunization documentation with Minnesota's immunization information system:

______________________________
Signature of parent or legal guardian Date