Clear Form

DEPARTMENT OF HUMAN SERVICES

DHS-7776-ENG 9-19

Family Child Care Admission and Arrangements

PLEASE PRINT. Complete one form for each child in care. This form must be kept on file at the family child care home. Please Note: Pursuant to MN Rules 9502.0405, subpart 4, the provider shall obtain the required information for each child prior to admission and keep the information up to date.

CHILD INFORMATION

Last Name	First Name	Birthdate (mm/dd/yyyy)	Date Enrolled in Care

Address	City	State	Zip Code

PARENT OR GUARDIAN # 1

Last Name	First Name	Place of Employment and Work Phone No.

Address of Employer	City	State	Zip Code

Email	Home Phone	Cell Phone

Address (if different from child)	City	State	Zip Code

PARENT OR GUARDIAN # 2

Last Name	First Name	Place of Employment and Work Phone No.

Address of Employer	City	State	Zip Code

Email	Home Phone	Cell Phone

Address (if different from child)	City	State	Zip Code

EMERGENCY CONTACT FOR CHILD IF PARENTS CAN'T BE REACHED

One Contact Required

Last Name	First Name	Relationship and Phone Number

Address	City	State	By checking I am authorizing this person to pick up my child ☐

Last Name	First Name	Relationship and Phone Number

Address	City	State	By checking I am authorizing this person to pick up my child ☐

Last Name	First Name	Relationship and Phone Number

Address	City	State	By checking I am authorizing this person to pick up my child ☐

EMERGENCY INFORMATION FOR CHILD

Hospital to be used for emergencies	Physician's Name	Telephone

Address	City	State	Zip Code

Dentist to be used for emergencies	Dentist's Name	Telephone	If you don't have a dentist yet for your child, check this box ☐

Address	City	State	Zip Code

CHILD CARE PROVIDER

Name	License #		
Address	City	State	Zip Code

ARRANGEMENTS

Financial Arrangements

Services Provided (Including Days, Hours, Meals, Etc.)

Special Conditions (Special Diet, Special Needs)

Does Your Child Have Allergies YES NO NOTE: If Yes, Complete the Allergy Information Form

LIABILITY INSURANCE NOTIFICATION

Pursuant to 245A.152(a) A license holder must provide a written notice to all parents or guardians of all children to be accepted for care prior to admission stating whether the license holder has liability insurance. This notice may be incorporated into and provided on the admission form used by the license holder. Select one of the options below.

I do have liability insurance. A current certificate of coverage of insurance is available for inspection to all parents and guardians of children receiving services and to all parents seeking services from the family child care program. The expiration date is:

I do not have liability insurance

PERMISSIONS

AUTHORIZATION IS HEREBY GIVEN TO THE CHILD CARE PROVIDER AS NAMED IN THE ITEM ABOVE, TO PROVIDE TRANSPORTATION FOR MY CHILD
Yes No

ANY SPECIAL TRAVEL ARRANGEMENTS

I have received a copy of the maltreatment of minors mandated reporter policy

AUTHORIZATION IS HEREBY GIVEN TO THE CHILD CARE PROVIDER AS NAMED IN THE ITEM ABOVE, TO OBTAIN EMERGENCY MEDICAL CARE OR TREATMENT IN THE EVENT OF AN EMERGENCY Yes No

AUTHORIZATION: We the undersigner hereby agree to abide by the arangements and authorizations so stated above. We have discussed the information required in the rule part 9502.0405

Signature of Child Care Provider	Date
Signature of Parent / Guardian	Date
Signature of Parent / Guardian	Date

Updated
9-2019

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								
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)

EMERGENCY CONTACTS AND PERMISSION TO DROP OFF AND PICK UP

Name_____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail Address: _____

Address _____

Relationship: _____

_____

Name_____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail Address: _____

Address _____

Relationship: _____

_____

Name_____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail Address: _____

Address _____

Relationship: _____

_____

Name_____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail Address: _____

Address _____

Relationship: _____

_____

Clear Form

DEPARTMENT OF HUMAN SERVICES

DHS-7736-ENG 7-17

Family Child Care Allergy Information Form

PLEASE PRINT: Complete one form for each child. This form must be kept on file at the family child care home. Please Note: Pursuant to MN Statute 245A.51, subd. 1, before admitting a child for care, the license holder must obtain information about any known allergy from the child's parent or legal guardian. The child allergy information must be documented on a form approved by the commissioner, readily available to all caregivers, and reviewed annually by the license holder and each caregiver.

CHILD INFORMATION

Last Name	First Name	Birthdate (mm/dd/yyyy)

PARENT OR GUARDIAN

Last Name	First Name	Phone No.

Physician's Name	Physician's Number

1. Please indicate items your child has an allergy to:

- ☐ Peanut / Peanut Products
- ☐ Fish / Shellfish
- ☐ Eggs
- ☐ Milk
- ☐ Soy Products
- ☐ Gluten
- ☐ Nuts
- ☐ Bee Stings
- ☐ Other (please indicate): _____

2. What things trigger an allergic reaction in your child?

3. What thing should be avoided due to the allergy?

4. What are the sign and symptoms of your child's allergic reaction? Be specific.

5. What treatment or medication does your child have in the event of an allergic reaction? (include doses):

6. What are the procedures for responding if your child has an allergic reaction?

Signature of Parent / Guardian	Date

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ያስተውሉ፡ ይህንን ዶኩመንት ለመተርጎም እርዳታ የሚፈልጉ ከሆነ፡ የጉዳዮን ሰራተኛ ይጠይቁ ወይም በሰልክ ቁጥር 1-844-217-3547 ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ သင့်လူမှုရေးအလုပ်သမား အားမေးမြန်း ခြင်းသို့ မဟုတ် 1-844-217-3563 ကိုခေါ်ဆိုပါ။

កំណាត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកការងារសង្គមរបស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

請注意，如果您需要免費協助傳譯這份文件，請告訴您的工作人員或撥打1-844-217-3564。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, demandez à votre agent chargé du traitement de cas ou appelez le 1-844-217-3548.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ဟ်သူဉ်ဟ်သးဘဉ်တကွ်ာ်. ဖဲနမ့ာ်လိဉ်ဘဉ်တာ်မၤစၢၤကလီလၢတာ်ကကျိးထံဝဲဒဉ်လံာ် တိလံာ်မိတခါအံၤန္ဉ်,သံကွါဘဉ်ပှၤဂ့ၢ်ဝိအပှၤမၤစၢၤတာ်လၢနဂီၢ်မ့တမ့ာ်ကိးဘဉ် 1-844-217-3549 တကွ်ာ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 담당자에게 문의하시거나 1-844-217-3565으로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມພະນັກງານກ່ຽວກັບການຊ່ວຍເຫຼືອ ຂອງທ່ານ ຫຼື ໂທຣໄປທີ່ 1-888-487-8251.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbili 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LB1 (8-16)

ADA4 (9-15)

ADA Advisory

For accessible formats of this publication or assistance with additional equal access to human services, contact your county's ADA Coordinator

DEPARTMENT OF HUMAN SERVICES
LICENSING DIVISON

Prescription and non-prescription medication administration permission

Family Child Care

9502.0435 subp. 16 F (1) The provider shall obtain written permission from the child's parent prior to administering prescription and non-prescription medicines, diapering products, sunscreen lotions, and insect repellents. Nonprescription medicines, diapering products, sunscreen lotions, and insect repellents must be administered according to the manufacturer's instructions unless there are written instructions for their use provided by a licensed physician or dentist.

The provider shall obtain and follow written instructions from a licensed physician or dentist prior to administering each prescription medicine. Medicine with the child's name and current prescription information on the label constitutes instructions.

Product	Parent Signature APPROVES	Parent Signature DOES NOT APPROVE
Prescription and Non-Prescription Medicines		
Diapering Products		
Sunscreen Lotions		
Insect Repellents		

Additional information for provider:

DEPARTMENT OF HUMAN SERVICES
LICENSING DIVISON

Directive for Alternative Infant Sleep Position

This form is the approved format to direct an alternative sleep position and must remain on file at the licensed location.

The American Academy of Pediatrics (AAP)* and the National Institute of Child Health and Human Development (NICHD) recommend back sleeping for babies to reduce the risk of sudden unexpected infant deaths (SUID) due to sudden infant death syndrome, suffocation, and other sleep related causes. The AAP further states that an alternative sleep position be considered only for the rare exception of infants for whom the risk of death when sleeping on the back is greater than the risk of SUID when sleeping on the stomach.

Sleeping babies are safest on their backs.

Minnesota law requires that licensed providers place infants to sleep in a crib, directly on a firm mattress. The provider must place the infant on his/her back for sleep unless the provider has a signed directive from a physician or an advanced practice registered nurse (APRN) for an alternate sleep position for the infant. Car seats, swings, couches, the floor on a blanket, etc. are **not** acceptable as an alternative sleep position.

In addition, Minnesota law requires licensed providers to use a fitted crib sheet that fits tightly on the mattress and overlaps the underside of the mattress so it cannot be dislodged by pulling on the corner of the sheet with reasonable effort. Nothing may be placed in the crib with the infant except the infant's pacifier. These requirements apply to license holders serving infants up to one year of age. Licensed providers may only use cribs that meet requirements specified in statute and must inspect cribs monthly to assure they are safe.

I understand that back sleeping is recommended and is safest for babies. I am directing an alternative position for this infant for the reason(s) stated below. By signing this form, I acknowledge that I am directing only an alternative sleep position and that the infant must always be placed in an approved crib to sleep.

NAME OF CHILD	DATE OF BIRTH

_____ Place this infant on his/her STOMACH for sleep periods (***not recommended); OR***

_____ Place this infant on his/her SIDE for sleep periods (***not recommended)***

Medical Reason(s) for alternate sleep position:

_____

(Attach information if necessary)

Expected duration of need for alternate sleep position:

_____

List the date the infant will be re-evaluated for the need for an alternative sleep position by a physician or advanced practice registered nurse:

_____

PRINTED NAME OF PHYSICIAN OR APRN	DATE

SIGNATURE OF PHYSICIAN OR APRN

(Licensed providers must place an infant in a crib to sleep. Car seats, swings, couches, the floor on a blanket, etc. are <u>not</u> acceptable as an alternative sleep position.)

ALTERNATIVE INFANT SLEEP POSITION PARENT AUTHORIZATION

One of the easiest ways to lower a baby's risk of Sudden Unexpected Infant Death (SUID) due to sudden infant death syndrome (SIDS), suffocation, and other sleep related causes is to put the baby on the back to sleep for naps and at night. Health care providers used to think that babies should sleep on their stomachs, but research now shows that babies are less likely to die of SUID when they sleep on their backs. Since the recommendation to place a baby on their back for sleep began, the SIDS rate in the United States has dropped by more than 50 percent. Placing babies on their back to sleep is the best way to reduce the risk of SUID.

The following are recommended for Safe Sleep for Your Baby:

1. Always place a baby on his or her back to sleep, for naps and at night. The back sleep position is the safest position for all babies and every sleep time counts.
2. A baby should be put to sleep in a safety-approved crib on a firm mattress covered by a fitted sheet appropriate to the mattress size.
3. Keep soft objects, toys, loose bedding, pillows, blankets, quilts, sheepskins and crib bumpers out of the baby's sleep area. The only item that should be placed in the crib with the baby is a pacifier. **Please note: In licensed programs, the only item allowed in a crib with an infant is a pacifier.**

• As the parent providing this physician signed form I acknowledge that I have read the above information regarding the AAP and NICHD recommendations for sleeping babies safely, Minnesota's requirements for licensed providers, and recommendations from **Safe Sleep for Your Baby**.

The Safe Sleep for Your Baby Brochure may be viewed at:
https://www.nichd.nih.gov/sites/default/files/publications/pubs/Documents/NICHD_Safe_to_Sleep_brochure.pdf

• As the parent providing this physician signed form, I acknowledge that I am aware that placing a baby on her/ his back for sleep has been recommended by health experts to be the safest way to place a baby for sleep.

• As the parent providing this physician signed form, I acknowledge that I am aware that since the recommendation to place babies on their back for sleep began, the SIDS rate in the United States has dropped by more than 50 percent.
• As the parent providing this physician signed form, I acknowledge that I am aware that placing a baby on the stomach or side, places the baby at greater risk for dying from Sudden Unexpected Infant Death (SUID).

• As the parent providing this physician signed form, I acknowledge that I am aware that Minnesota Statutes, Section 245A.1435, requires licensed providers to position an infant on the back for sleep unless the provider has a signed directive from a physician or APRN for an alternate sleep position.

SIGNATURE OF PARENT	DATE
SIGNATURE OF PROVIDER	DATE

Note: The second and third pages of the Alternative Infant Sleep Position form must be signed by the appropriate people and remain on file.

**AAP Task Force on Sudden Infant Death Syndrome. SIDS and Other Sleep-Related Infant Deaths: Updated 2016 Recommendations for a Safe Infant Sleeping Environment. Pediatrics 2016. 138(5) available at https://pediatrics.aappublications.org/content/138/5/e201629388*

DEPARTMENT OF HUMAN SERVICES
LICENSING DIVISON

Infant Rolling over Parent Statement for Infant Less Than Six Months Old

****Please Note: The use of this form for the parent's signed statement is optional****

An infant who independently rolls onto its stomach after being placed to sleep on its back may be allowed to remain sleeping on its stomach if the infant is at least six months of age or the license holder has a signed statement from the parent indicating that the infant *regularly rolls over* at home. Minnesota Statutes, section 245A.1435

Name of Infant: _____

Date of Birth of Infant (MM/DD/YYYY): _____

By completing this form, I (the parent) attest that my infant *independently and regularly rolls over onto its stomach* after being placed to sleep on its back. I (the parent) acknowledge that while in the care of the licensed program, my infant will be placed on its back to sleep and that when my infant independently rolls over onto its stomach while sleeping, the license holder may allow my infant to remain sleeping on its stomach.

Name of Parent or Legal Guardian: _____

Signature of Parent or Legal Guardian: _____ Date: _____

Name of Parent or Legal Guardian: _____

Signature of Parent or Legal Guardian: _____Date:_____

DEPARTMENT OF HUMAN SERVICES
LICENSING DIVISON

Swaddling Consent for an Infant

Placing a swaddled infant down to sleep in a licensed setting is *not* recommended for an infant of any age* and is prohibited for any infant who has begun to roll over independently.

However, with written consent of a parent or guardian, a license holder may place the infant who has NOT YET BEGUN to ROLL OVER ON ITS OWN down to sleep in a crib, on their back, in a one-piece sleeper equipped with an attached system that fastens securely ONLY across the upper torso, with no constriction of the hips or legs, to create a swaddle.

Any other type of swaddle, including with a blanket, is prohibited.

Prior to any use of swaddling for sleep by a licensed provider, the license holder must obtain informed written consent for the use of swaddling from the parent or guardian of the infant. The parent or guardian must demonstrate to the provider how to safely place baby in the swaddle so it is not too tight or too loose.

I _____, the parent/guardian of _____ DOB _____
(Parent) (Infant)
give written consent to _____
(Provider)
to place my infant to sleep in a crib, on their back, in a one-piece sleeper equipped with an attached system ("wings") that fastens securely ONLY across the upper torso to create a swaddle.

_____I verify that my infant has NOT yet begun to roll over.
_____I verify that the provider will only use the one-piece sleeper to swaddle my infant
_____I verify that the provider has a one-piece sleeper with attached "wings" OR
_____I verify that I have provided the one-piece sleeper with attached "wings"
_____I verify that I have demonstrated to the provider how to place baby in the swaddle.
_____I verify that I will immediately notify the provider when my infant has begun to roll over.

Signature of Parent _____ Date _____

Signature of Provider_____ Date _____

At the time that the parent or provider observes that this infant has begun to roll over, this parental consent is no longer valid.

Infant has begun to roll over. Swaddling has been discontinued.

Date: _____ Provider Initials: _____Parent Initials: _____

*Caring for our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, Third Edition 2012.