School Age Child Care

Phone: 507.765.3809 Ext. 1189 Cell: 507.696.2507

2022-2023 School Year Contract Due On August 19th, 2022

_____ $20 Registration Fee
_____ Registration Form
_____ Authorized Pick Up/Emergency Information
_____ Allergies Form (if has allergies everything needs to be filled out)
_____ Medical and Emergency Release Information
_____ Immunization **if new to the program**
_____ Emergency Procedure
_____ Admission Agreement

- Certified program kindergarten through 6th grade. Certified # 1089375
- All staff CPR/First Aid/AED certified.
- Thoughtfully planned and developmentally appropriate activities.
- Drop-ins (with 24-hour notice) are always welcome, pending availability.
- Open 6:00a to 6:00p Monday through Friday.
- Payment is expected weekly unless otherwise arranged.
- Incase of illness, the center must be notified of your child's absence by **7:00 AM**.
- SACC welcomes full-time and part-time enrollments. If you are unable to receive care at SACC due to space limitations, your name will be placed on a prioritized waiting list. Completed Contract is required to be on the waitlist.

School Age Child Care Closed Date 2022-2023

Staff Development - November 23
Thanksgiving & Friday after - November 24 & 25
Christmas - December 23 & 26
New Years - December 30
Presidents' Day - February 20
Good Friday - April 7
Memorial Day - May 29
Staff Development - June 2
Independence Day - July 4
SAC Cleaning, Repairs & Prepare for the school year - August 14-September 6
If we are able to re-open prior to September 6, 2023, we will communicate this to families as soon as we know. Thank you for your understanding.
Labor Day - September 4

No School Days Contract

Contracts will be sent out to families a month in advance of a no school day. SAC will be open if a minimum of 12 students sign up. SAC required a minimum of 5-hours commitment on a no school day. By requesting programming for your family, you have made your commitment and NO CANCELLATION WILL BE ACCEPTED.

Each blank is required information as determined by School Age Children and our certification. Students will not be permitted into care without a complete contract and registration packet.

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FILLMORE CENTRAL
SCHOOL AGE CARE and
YOUNG LEADERS PROGRAM
REGISTRATION FORM 2022-2023 SCHOOL YEAR

Date_____

Child's Name:

1._____ _____ Birth Date:_____
Last First
Grade 2022-2023_____

2._____ _____ Birth Date:_____
Last First
Grade 2022-2023_____

3._____ _____ Birth Date:_____
Last First
Grade 2022-2023_____

*A $20.00 non-refundable Registration Fee per family (semi-annually) is due at the beginning of school year and beginning of summer SAC.

SAC Rates:
K-6th – $3.35 per hour
Drop in rates – $4.50
Families of 2 or more receive a 5% discount off the hourly rate per additional child.

Child lives with: Both Parents Father Mother Other:_____

MOTHER'S/GUARDIAN'S NAME:_____

Address:_____
City Zip Code

Home Phone:_____ E-Mail Address:_____

Cell Phone:_____ Work Phone:_____

Place of Employment:_____ Occupation:_____

FATHER'S/GUARDIAN'S NAME:_____

Address:_____
City Zip Code

Home Phone:_____ E-Mail Address:_____

Cell Phone:_____ Work Phone:_____

Place of Employment:_____ Occupation:_____

SIBLINGS: (not in SAC)

NAME AGE

_____

_____

AUTHORIZED PICK UP/EMERGENCY INFORMATION: List 3 persons who may be contacted in case of an emergency, other than the parents/guardians. These people will also be authorized to pick up your child from Fillmore Central School Age Care:

NAME_____ PHONE_____

ADDRESS_____

NAME_____ PHONE_____

ADDRESS_____

NAME_____ PHONE_____

ADDRESS_____

List persons **NOT** authorized to take children from the program. Copy of legal documents must be provided to staff.

_____

_____

Below write any medical problems that we; the staff at Fillmore Central School Age Care, need to be aware of. Please explain your answers, and if it does not apply to your child write N.A.

1. I would like staff to be aware of the following needs regarding my child. (i.e. Emotional Behavior Disorder, Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder, others)

2. I would like staff to be aware of the following family situation. (i.e. may include transportation/busing, recent death in the family, custody issue)

3. I would like to share the following information as it relates to my child's socialization skills and personality traits. (i.e. shy, active, likes outdoors, sensitive)

Medications child takes on a regular basis:_____

If child receives student support in the classroom, has an identified special need, behavior concerns or an Individualized Education Program (IEP) developed, identify here: _____

_____

Any other issues we should be aware of to help us better care for your child: _____

_____

_____

Please "X" any of the following health concerns that apply:

___ADD	___Bloody Noses	___Hearing or Vision Problems
___ADHD	___Diabetes	___Bladder/Bowel Problems
___Seizures	___Asthma or Breathing Problems	

___Other, please explain_____

_____

FC SACC- Teacher information Form 2022-2023

Child's Name_____ Nickname_____ Date of Birth_____

Child's Name_____ Nickname_____ Date of Birth_____

Child's Name_____ Nickname_____ Date of Birth_____

Does your child have more than 1 home?_____ Explain:_____

_____

Special instructions (As to care, allergies, tubes, ext.)_____

_____

What is most important to you about your child's environment while in our care?_____

_____

Child's favorite activities, like, dislikes, fears, ect. _____

_____

_____

Please note any major changes in your family situation in the last year or in the near future_____

_____

_____

Does your child have any communication habits that we should know about?_____

_____

_____

What is your effective method for comforting your child?_____

_____

_____

What is important to you regarding our staff?_____

_____

_____

Additional information and/or comments_____

_____

_____

_____

_____

Medical and Emergency Release Information

In case of an emergency, accident or serious illness to the child named above in which medical treatment is required, I (parent/guardian) request Fillmore Central School Age Care to contact me. If they are unable to reach one of the above-designated persons, my signature below authorizes Fillmore Central School Age Care to exercise their own judgment if contacting the physician is unavailable, Fillmore Central School Age Care may make whatever arrangements are necessary.

PHYSICIAN:_____ PHONE:_____

ADDRESS:_____

City

PREFERRED EMERGENCY HOSPITAL:_____

I give permission for the following:

Yes / No 1. For my child to be photographed and/or video while attending Fillmore Central School Age Care. I understand these photos may be published in Newspapers, brochures, magazines or other printed media.

Yes / No 2. For my child to go on field trips in an authorized vehicle. I understand that I will be notified of the dates, times and destinations of the field trips.

Yes / No 3. I give permission for the staff at Fillmore Central School Age Care to administer ipecac syrup if prescribed by Poison Control.

_____ _____

Parent/Guardian Signature Date

PLEASE NOTIFY FILLMORE CENTRAL SCHOOL AGE CARE IF THERE ARE ANY CHANGES!!

FILLMORE CENTRAL
SCHOOL AGE CARE and
YOUNG LEADERS
ADMISSION AGREEMENT

Please sign and return on or before your child(ren's) first day of attendance.

I, _____ agree to contract for the following days and hours:
I agree to follow the policies and procedures as stated in the handbook.

Child's Name: _____ Child's Name: _____

Child's Name: _____ Child's Name: _____

Please fill out below the times your child(ren) will be coming each day. This will be your contract time.

DAY	ARRIVAL	DEPARTURE
Monday	_____	_____
Tuesday	_____	_____
Wednesday	_____	_____
Thursday	_____	_____
Friday	_____	_____

PLEASE BE SURE TO LET SAC KNOW IF YOUR SCHEDULE CHANGES.

Remember our staffing needs are based on the number of children and the times that they are scheduled to be at SAC. If you fail to notify by 7 a.m. the day of, that your child won't be there, you will be charged $25 for the day. Exceptions will be made in emergency situations.

_____ _____

Parent/Guardian Signature Date

DEPARTMENT OF HUMAN SERVICES

DHS-7995A-ENG 2-22

OFFICE OF INSPECTOR GENERAL - LICENSING DIVISION

Child Allergy Information Form

DATE	PROGRAM NAME		CERTIFICATION NUMBER
	Fillmore Central School Age Child Care		1089375
CHILD'S FIRST NAME	MI	LAST NAME	DATE OF BIRTH

Allergy information

Describe the allergy. Allergies with similar symptoms can be listed together. Additional section(s) can be added for multiple allergies with different triggers, symptoms, and techniques.

What triggers the allergy?

All symptoms below may be experienced when exposed to an allergen. Please select any known symptoms the child may display:

- ☐ **No history of symptoms or unknown**
- ☐ **Mouth: Itching; tingling; swelling of lips, tongue or mouth ("mouth feels funny")**
- ☐ **Skin: Hives; itchy rash; swelling of the face or extremities**
- ☐ **Gut: Nausea; abdominal cramps; vomiting; diarrhea**
- ☐ **Throat: Difficulty swallowing; hoarseness; hacking cough**
- ☐ **Lungs: Shortness of breath; repetitive coughing; wheezing**
- ☐ **Heart: Weak or fast pulse; low blood pressure; fainting; pale; blueness**
- ☐ **Other:**

IF NEEDED, PLEASE LIST ANY ADDITIONAL INFORMATION REGARDING SYMPTOMS

What techniques will be used to avoid an allergic reaction?

What procedures will be taken to respond to an allergic reaction for this child?

Medications for responding to an allergic reaction

Are medications required for response to an allergic reaction for this child? ◯ Yes ◯ No

MEDICATION	DOSAGE

Medication administration requirements (permission to administer, when and how to administer, and documentation of administration) must be followed according to Minn. Stat. 245H.13, subd. 3. The medication and dosage information documented here does not fulfill those requirements.

Doctor information - Call 911 for EMERGENCIES

DOCTOR NAME	DOCTOR PHONE NUMBER

Allergy information available at all times

A child's allergy information must be available at all times, including on-site, when on field trips, or during transportation. Food allergy information must be readily available to a staff person in the area where food is prepared and served to the child per Minn. Stat. 245H.13, subd. 4(c).

Staff caring for the child

The following staff have reviewed the allergy information form and agree to follow the plan.

Print Staff Name	Signature	Date

In Minn. Stat. 245H.13, subd. 4(c), staff training requirements for child allergy information must be followed. Staff persons must be informed of child allergy information at least annually and when a change is made to allergy-related information in a child's record.

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)

FILLLMORE CENTRAL ELEMENTARY SCHOOL

EMERGENCY PROCEDURE

PLEASE COMPLETE BOTH SIDES OF THIS FORM AND RETURN A.S.A.P

Student's Name:_____
(Last) (First) (Middle)

Birthdate:_____Sex:_____Grade:_____Teacher:_____

Home Address:_____Home Phone:_____

Email Address:_____Cell Phone:_____

Parent or Guardian:_____ _____
Father or Guardian Mother or Guardian

Student lives with: Both Parents Father Mother Other:_____

LOCATIONS PARENTS CAN BE REACHED IF NOT AT HOME:

Father:_____
Business Name Location/Address Hours/Days Phone

Mother:_____
Business Name Location/Address Hours/Days Phone

IF PARENTS CANNOT BE REACHED DURING THE DAY, PLEASE NAME A LOCAL PERSON OR RELATIVE WHO WOULD BE ABLE TO PICK YOUR CHILD UP IF HE/SHE BECOMES ILL DURING SCHOOL HOURS:

Name:_____
Relationship

Address:_____Phone:_____

RELEASE: In case of emergency, accident or serious illness to the student named on this form in which medical treatment is required, I (parent/guardian) request the school to contact me. If the school is unable to reach one of the above designated person, my signature below authorizes the school to exercise their own judgment in contacting the physician indicated on the back side of this form and to follow his/her instructions. If this physician is unavailable, the school may make whatever arrangements are necessary or transport the student to a hospital emergency room.

Parent/Guardian Signature:_____
Date

Remarks:_____

OVER

Does this student have any major or unusual health conditions? Yes No

If yes, please specify:_____

Allergies: Yes No If yes, list allergens:_____

Asthma: Yes No If yes, list medications:_____

Other health concerns:_____

Local Physician's Name:_____

Office Address:_____Office Phone:_____

Preferred Emergency Hospital:_____

IMPORTANT NOTE:
PLEASE NOTIFY JESSICA BRADT OF ANY CHANGES!