

STUDENT'S LEGAL LAST NAME			FIRST NAME	MIDDLE NAME
STUDENT'S 911 ADDRESS				
STUDENT'S MAILING ADDRESS			APT. NO.	RES. DIST.
CITY	STATE	ZIP CODE	STUDENT HOME PHONE	
E-MAIL ADDRESS		MASS CALLING PHONE NUMBER(S) FOR SCHOOL CLOSINGS, ETC.		
		PHONE #1	PHONE #2	
HAS STUDENT EVER REGISTERED UNDER A DIFFERENT NAME?				
<input type="checkbox"/> NO <input type="checkbox"/> YES NAME: _____				
STUDENT'S BIRTHDATE		STUDENT'S BIRTH PLACE		STATE COUNTY
MO.	DAY	YEAR	CITY	
			STUDENT'S RACE / ETHNICITY - Please CIRCLE ONE for each Category: AMERICAN INDIAN/ALASKA NATIVE Y or N ASIAN Y or N BLACK / AFRICAN AMERICAN Y or N HISPANIC / LATINO Y or N NATIVE HAWAIIAN/PACIFIC ISLANDER Y or N WHITE Y or N	
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<input type="checkbox"/> BOTH PARENTS <input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> MOTHER & STEPFATHER <input type="checkbox"/> FATHER & STEPMOTHER <input type="checkbox"/> GUARDIAN <input type="checkbox"/> FOSTER PARENTS		WHICH PARENT PAYS LUNCH?
MOTHER'S LAST NAME		FIRST NAME	MIDDLE INITIAL	
MOTHER'S HOME PHONE		MOTHER'S CELL PHONE		
ADDRESS OF MOTHER IF DIFFERENT FROM STUDENT'S				
CITY		STATE	ZIP	
MOTHER'S EMPLOYMENT		BUSINESS PHONE	EXT.	
FATHER'S LAST NAME		FIRST NAME	MIDDLE INITIAL	
FATHER'S HOME PHONE		FATHER'S CELL PHONE		
ADDRESS OF FATHER IF DIFFERENT FROM STUDENT'S				
CITY		STATE	ZIP	
FATHER'S EMPLOYMENT		BUSINESS PHONE	EXT.	
NAME OF THE ADULT PERSON(S) THE STUDENT LIVES WITH IF OTHER THAN A MOTHER OR FATHER:				
LAST	FIRST	DAYTIME PHONE	EXT.	
NAME OF A PERSON TO CALL IN AN EMERGENCY OTHER THAN A PERSON THE STUDENT LIVES WITH:				
EMERGENCY NAME		DAYTIME PHONE	EXT.	
RELATIONSHIP TO STUDENT				
SIGNATURE		RELATIONSHIP TO STUDENT		

STUDENT NAME: _____

ALBANY AREA SCHOOLS DISTRICT #745 - STUDENT REGISTRATION FORM

TODAY'S DATE MO		DAY		YEAR		IS THIS STUDENT (OR ARE YOU) HISPANIC/LATINO? <i>(Choose only one)</i> <input type="checkbox"/> No, Not Hispanic/Latino <input type="checkbox"/> Yes, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race.) The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicated what you consider your student' (or your) race to be.
START DATE MO		DAY		YEAR		
GRADE LEVEL		SCHOOL				WHAT IS STUDENT (OR YOUR) RACE? <i>(Choose one or more)</i> <input type="checkbox"/> American Indian or Alaska Native (A person having origins in any of the original peoples of North and South American (including Central America), and who maintains tribal affiliation or community attachment.) <input type="checkbox"/> Asian (A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.) <input type="checkbox"/> Black or African American (A person having origins in any of the black racial groups of African.) <input type="checkbox"/> Native Hawaiian or Other Pacific Islander (A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.) <input type="checkbox"/> White (A person having origins in any of the original peoples of Europe, the Middle East or North Africa.)
WAS STUDENT PREVIOUSLY ENROLLED IN ALBANY DISTRICT? <input type="checkbox"/> YES <input type="checkbox"/> NO						
SCHOOL MOST RECENTLY ATTENDED BY STUDENT						
DISTRICT NAME OR NO.		SCHOOL NAME				
CITY			STATE			HOME LANGUAGE (IF OTHER THAN ENGLISH): CAN AN ADULT IN THE HOME READ ENGLISH? <input type="checkbox"/> NO IF NO, WHAT LANGUAGE CAN BE READ? <input type="checkbox"/> YES
DATE LAST ATTENDED MO		DAY		YEAR		
						CITIZENSHIP STATUS OF STUDENT <input type="checkbox"/> AMERICAN CITIZEN <input type="checkbox"/> STATUS PENDING ENTRANT <input type="checkbox"/> STUDENT VISA <input type="checkbox"/> VISITOR VISA <input type="checkbox"/> REFUGEE <input type="checkbox"/> IMMIGRANT <input type="checkbox"/> OTHER
TYPE OF SCHOOL LAST ATTENDED <input type="checkbox"/> PUBLIC <input type="checkbox"/> NONPUBLIC						
HAS THIS STUDENT EVER RECEIVED SPECIAL EDUCATION SERVICES? <input type="checkbox"/> NO IF YES, IN WHAT SCHOOL DISTRICT(S) : <input type="checkbox"/> YES						
MAILING INFORMATION: SCHOOL MAILINGS MAY BE SENT TO ALTERNATE MAILING ADDRESS IN ADDITION TO OR IN PLACE OF THE STUDENT'S ADDRESS. CHECK BELOW WHERE TO SEND SCHOOL MAILINGS: <input type="checkbox"/> STUDENT ADDRESS ONLY <input type="checkbox"/> ALTERNATE MAILING ADDRESS ONLY <input type="checkbox"/> BOTH STUDENT ADDRESS & ALTERNATE ADDRESS PROVIDE CHOSEN ALTERNATE MAILING ADDRESS HERE:						
NON-CUSTODIAL PARENT RESTRICTIONS: (IF ANY PROVIDE COURT DOCUMENTS - VISITATION/PHONE ETC.) <input type="checkbox"/> CUSTODY/PARENT RESTRICTIONS APPLICABLE COURT DOCUMENTS HAVE BEEN PROVIDED <input type="checkbox"/> NA						
NAME				DAY CARE PROVIDER (IF ANY)		
ADDRESS			APT. NO.		PHONE	
CITY		STATE	ZIP	ADDRESS		
OTHER CHILDREN IN THIS SAME HOUSEHOLD: BROTHERS, SISTERS, STEPBROTHERS, STEPSISTERS, FOSTER BROTHERS, FOSTER SISTERS, OR OTHER						
FIRST NAME		LAST NAME		BIRTHDATE	SEX	
OFFICE USE ONLY				BIRTHDATE & LEGAL NAME VERIFIED BY:		
MN STATE STUDENT ID NUMBER				<input type="checkbox"/> BIRTH CERTIFICATE <input type="checkbox"/> PASSPORT <input type="checkbox"/> BAPTISMAL RECORD <input type="checkbox"/> OTHER		
HAS IMMUNIZATION INFORMATION BEEN GIVEN TO THE SCHOOL'S HEALTH OFFICE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> INCOMPLETE <input type="checkbox"/> NA INITIALS				WHO IDENTIFIED STUDENT'S ETHNICITY? <input type="checkbox"/> PARENT/GUARDIAN/STUDENT OR OTHER FAMILY MEMBER <input type="checkbox"/> SCHOOL STAFF <input type="checkbox"/> OTHER		

KINDERGARTEN INFORMATION FORM

Child's Full Name: _____

Child's Full Birth Date: _____

Medical or Allergy Concerns: _____

Father's Name: _____

Father's Address: _____

Workplace: _____

Cell Phone Number: _____

Work Number: _____

Parent Email: _____

Please list all of the adults living in your child's household:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Mother's Name: _____

Mother's Address: _____

Workplace: _____

Cell Phone Number: _____

Work Number: _____

Parent Email: _____

Please list all of the adults living in your child's household:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

After School Plans:

Bus Number: _____ Days Attending Kid's Company: _____

Picked up by: _____ Walking to/with: _____

If you cannot be reached, please list the name and phone numbers of your daycare if applicable and at least two other emergency contact people.

Name: _____ Relationship: _____

Home Number: _____ Cell Number: _____

Name: _____ Relationship: _____

Home Number: _____ Cell Number: _____

Name: _____ Relationship: _____

Home Number: _____ Cell Number: _____

Please describe any health concerns:

Please circle the programs that your child has been involved with:

Daycare ECFE/ECSE/Preschool Learning Readiness Head Start

What are your child's major strengths?

Describe your child's feelings about school.

How does your child get along with other children?

Please describe recent family changes or events. (e.g. death, divorce, new sibling, moving).

How do you feel that I can best help your child this year?

Is there anything else that would be beneficial for me to know about your child?

ALBANY AREA SCHOOLS Kindergarten Health Record

Parent or guardian to complete this section before student is examined by Health Care Provider

Name _____ M _____ F _____ Date of birth _____
 Address _____ City _____ Phone _____
 Parent(s)/Guardian _____
 Physician _____ Dentist _____

Significant Health History

Parent or guardian to check conditions that apply & enter approximate date of diagnosis

CHECK THOSE THAT APPLY	DATE	CHECK THOSE THAT APPLY	DATE
Allergy, specify food, drug, environmental		Diabetes	
Asthma		Emotional problem, specify	
Behavioral disorder, specify		Orthopedic problem, specify	
Congenital condition, specify		Seizure disorder	
Chicken pox		Surgery, specify	
Chiropractic care for, specify		Other	

Health Exam

Physician to complete

Height	Eyes	Heart	Allergies
Weight	Ears	Neurologic	Nutrition
Heart rate	Nose	Bones/Joints	TB test
BP	Throat	Scoliosis	Date:
U/A	Glands	Skin	Result:
Hgb	Lungs	Hernia	

Significant developmental history _____

Social/emotional problems _____

Hearing _____ Speech _____ Vision _____

List any special health concerns, recommendations or comments _____

List conditions that may limit participation in:

Classroom activity _____

Physical Education _____

Competitive sports _____

Approved for:

___ Full activity

___ Limited activity

Health Care Provider _____

Date _____

Student Immunization Form

Student Name _____

Birthdate _____ Student Number _____

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

FOR SCHOOL USE ONLY	
<input type="checkbox"/>	Complete booster required in _____
<input type="checkbox"/>	In process; 8 mos. expires _____
<input type="checkbox"/>	Medical exemption for _____
<input type="checkbox"/>	Conscientious objection for _____
<input type="checkbox"/>	Parental/guardian consent _____

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 school 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 vaccination history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-5503 or 800-657-3970.

School Personnel: Be sure to initial and date any new information that you add to this form after the parent/guardian submits it. Also, record combination vaccines (e.g., DTaP+HepB+IPV, Hib+HepB) in each applicable space.

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, DT) • for children age 6 years and younger • final dose on or after age 4 years						
Tetanus and Diphtheria (Td) • for children age 7 years and older • 3 doses of Td required for children not up to date with DTaP, DTP, or DT series above						5th dose not required if 4th dose was given on or after the 4th birthday
Tetanus, Diphtheria and Pertussis (Tdap) • for children in 7th - 12th grade						
Polio (IPV, OPV) • final dose on or after age 4 years						4th dose not required if 5th dose was given on or after the 4th birthday
Measles, Mumps, and Rubella (MMR) • minimum age: on or after 1st birthday						
Hepatitis B (hep B)						
Varicella (chickenpox) • minimum age: on or after 1st birthday • vaccine or disease history required						
Meningococcal (MCV, MPSV) • for children in 7th - 12th grade • booster given at age 16 years						
Recommended						
Human Papillomavirus (HPV)						
Hepatitis A (hep A)						
Influenza (annually for children 6 months and older)						

Additional exemptions:

- **Children 7 years of age and older:** A history of 3 doses of DTaP/DTP/DT/Td/Tdap and 3 doses of polio vaccine meets the minimum requirements of the law.
- **Students in grades 7-12:** A Tdap at age 11 years or later is required for students in grades 7-12. If a child received Tdap at age 7-10 years another dose is not needed at age 11-12 years. However, if it was only a Td, a Tdap dose at age 11-12 years is required.
- **Students 11-15 years of age:** A 3rd dose of hepatitis B vaccine is not required for students who provide documentation of the alternative 2-dose schedule.
- **Students 18 years of age or older:** Do not need polio vaccine.

Student Name _____

Instructions, please complete:

Box 1 to certify the child's immunization status

Box 2 to file an exemption (medical or conscientious)

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. Received all required immunizations:

I certify that this student has received all immunizations required by law.

Signature of Parent / Guardian OR Physician / Public Clinic

_____ Date

B. Will complete required immunizations within the next 8 months:

I certify that this student has received at least one dose of vaccine for diphtheria, tetanus, and pertussis (if age-appropriate), polio, hepatitis B, varicella, measles, mumps, and rubella and will complete his/her diphtheria, tetanus, pertussis, hepatitis B, and/or polio vaccine series within the next 8 months.

The dates on which the remaining doses are to be given are:

Signature of Physician / Public Clinic

_____ Date

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

A. Medical exemption:

No student is required to receive an immunization if they have a medical contraindication, history of disease, or laboratory evidence of immunity. For a student 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 occurred before September 2010, a parent can sign.)

B. Conscientious exemption:

No student 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 student or others they come in contact with. In a disease outbreak schools may exclude children who are not vaccinated 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

3. Parental/Guardian Consent to Share Immunization Information (optional):

Your child's school is asking your permission to share your child's immunization documentation with MIIC, Minnesota's immunization information system, to help better protect students 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 school personnel to share my student's immunization documentation with Minnesota's immunization information system:

Signature of parent or legal guardian

_____ Date

ALBANY ELEMENTARY SCHOOL

SUPPLY LIST

KINDERGARTEN

1 Large School bag- without wheels-Labeled with your child's name
2 Boxes of tissues
2 Reams of white copy paper
2 Containers of Clorox or Lysol Wipes
Non-marking tennis shoes for Physical Education
1 Paint shirt-Art

1 Bottle of Elmer's liquid glue
4 Boxes of 24 count CRAYOLA crayons
1 Eight count CRAYOLA "Broad Line" markers (Classic Colors)
1 Eight count CRAYOLA "Thin Line" markers (Classic Colors)
15 Elmer's or Scotch brand glue sticks
2 Vinyl pocket folder with prongs
1 White 1 inch three ring binder
10 Pencils (yellow only)- sharpened
1 Big pink eraser
2 Packs of thin EXPO whiteboard markers (Black, Blue, Red, or Green only please)
1 Spiral bound notebook, plain colored
24 Pack CRAYOLA colored pencils
2 Yellow thick or broad highlighters
1 Crayola watercolors
1 Box of Ziploc type storage bags (sliders preferred)
- size by last name: A-J sandwich, K-R quart, S-Z gallon

*PLEASE DO NOT label school items unless stated above. We share all items as a class!