

OFFICE USE ONLY	_____ Student's Last Name (Legal only) Student's First Name (Legal only) Middle Name		
Student ID#	Birth Date	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Resident District if not Edina
SCHOOL #	Previous School District Name	Previous School Name	Grade at Previous School
Last Location	Last Date of Attendance	Start Date at the Edina Public Schools	Grade Entering
Dwelling #	Has student previously been enrolled in an Edina School? YES <input type="checkbox"/> NO <input type="checkbox"/>		Does student currently receive any of the following services? YES NO
Res Dist	Does your child receive Special Services or have an Individual Education Plan (IEP) ? YES <input type="checkbox"/> NO <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> 504 Plan (Americans with Disabilities Act) <input type="checkbox"/> <input type="checkbox"/> English as a Second Language <input type="checkbox"/> <input type="checkbox"/> Gifted/Talented
State Aid Cat	Proof of legal guardianship if student is living with someone other than parent.		In the definition used for this research, a homeless person is anyone who (1) lacks a fixed, regular, and adequate nighttime residence; and (2) has a primary nighttime residence that is a supervised, publicly- or privately-operated temporary living accommodation, including emergency shelters, transitional housing, and battered women's shelters; or 3) has a nighttime residence in any place not meant for human habitation, such as under bridges or in cars. This is based on the definition established by the U.S. Congress.
Family #	Is this student in foster care? YES <input type="checkbox"/> NO <input type="checkbox"/>	Is this student homeless? YES <input type="checkbox"/> NO <input type="checkbox"/>	
HOME LANGUAGE INFORMATION			
Family #	This information is used to determine if your student is eligible for the English Language Learner (ELL) program. In order to help your student learn, your student's teachers need to determine which language your student uses most.		
Trans Code	STUDENT PRIMARY LANGUAGE _____		
	1. Which language did your child learn first? _____		
	2. Which language is most often spoken in your home? _____		
	3. Which language does your child usually speak? _____		
	4. Do you need an interpreter for conferences, etc? YES <input type="checkbox"/> NO <input type="checkbox"/>		

I CERTIFY THE ABOVE INFORMATION IS CORRECT _____
Signature of Legal Parent/Guardian Date

Student Home Address

Address	Apt. #	City/State	Zip Code
Home Phone Number		Student Living with (please specify living arrangement)	
Move in Date	Move in Dist Date	Mailing address (if different)	

Parent/Legal Guardian Last Name	Parent/Legal Guardian First Name	Parent/Legal Guardian Middle
Work Number	Cell/Second Phone Number	Date of Birth
Address if different from above	City/State	Zip Code
Relationship to Student	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Email Address

Parent/Legal Guardian Last Name	Parent/Legal Guardian First Name	Parent/Legal Guardian Middle
Work Number	Cell/Second Phone Number	Date of Birth
Address if different from above	City/State	Zip Code
Relationship to Student	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Email Address

In compliance with federal regulations, have you moved to the Edina School District within the last 36 months for temporary or seasonal agricultural or fishing work? YES NO

Please list all children ages 0 — grade 12 (more room on back if needed)

LAST NAME	FIRST & MIDDLE NAME	GENDER	BIRTH DATE	SCHOOL	GRADE

OFFICE USE ONLY	
Proof of Residency:	<input type="checkbox"/> Purchase Agreement (must be follow by closing papers after the closing) <input type="checkbox"/> Closing Paper <input type="checkbox"/> Lease Agreement

Parent/Guardian Signature

Date

Last Name (Legal)	First Name (Legal)	Middle Name	Date of Birth
Country of Birth		If country of birth is not USA, date of first enrollment in a USA school	
Has this student completed three or more years of school in the USA? YES <input type="checkbox"/> NO <input type="checkbox"/>		Date _____ Year _____	

Race/Ethnicity Background Information— Please complete all sections, A, B and C.
 If any of the following sections are left unmarked, the district is mandated by federal law to choose for you.

- A. For state reporting purposes, please check the ONE response that best describes your child's primary racial/ethnic background:**
1. **American Indian or Alaska Native** (persons having origins in any of the original peoples of North America and maintain cultural identification through tribal affiliation or community recognition.)
 2. **Asian or Pacific Islander** (Persons having origins in any of the original peoples of the Far East, Southeast Asia, the Pacific Islands or the Indian subcontinent. This area includes China, India, Japan, Korea, Philippine Islands and Samoa.)
 3. **Hispanic** (Persons of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin—regardless of race.)
 4. **Black, not of Hispanic origin** (Persons having origins in any of the Black racial groups of Africa.)
 5. **White, not of Hispanic origin** (Persons having origins in any of the original peoples of Europe, North Africa or the Middle East.)

- B. For federal reporting purposes, check ONE answer—Child's Ethnicity**
1. YES—Hispanic or Latino (A persons of, Cuban, Mexican, Puerto Rican, South or Central American and other Spanish culture or origin, regardless of race.)
 2. NO—not of Hispanic or Latino
- C. For federal reporting purposes, check ALL that apply.**
1. **American Indian or Alaska Native** (persons having origins in any of the original peoples of North America and South America, including Central America and maintains a tribal affiliation or community attachment.)
 2. **Asian** (Persons 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, Philippine Islands, Thailand, Vietnam.)
 3. **Black, not of Hispanic origin** (Persons having origins in any of the Black racial groups of Africa.)
 4. **Native Hawaiian or other Pacific Islander** (A person having origins in any of the original people. Hawaii, Guam, Samoa or other Pacific Islands.)
 5. **White** (a person having origins in any of the original peoples of Europe, North Africa or the Middle East.)

Parent/Guardian Signature _____

Date _____



Edina Public Schools
Parent Input Form for Student Placement
 2012-13

We welcome you and your child to our school! There will be many different kinds of things for our students to do and we hope your child will be interested in the activities from the very first day. Because children have so many different interests, it takes a few weeks for us to get to know each child. This information will help your child's teacher become better acquainted with your child.

Child's name _____ Birth Date _____

Parent(s) name _____ Phone number _____

Has your child attended a nursery school, day care center, Montessori, etc.? _____

School _____

Years _____ Days per week _____ Hours per day _____

Request for AM ____ or PM ____ assignment due to special circumstances. Please explain:

NOTE: We will do everything possible to honor this request, however, there is no guarantee that we will be able to accommodate all special requests.

Each spring Edina Public Schools staff work to develop class lists for the coming year, striving to create classes where optimum learning for all students can take place. We value a strong family-school partnership. It is our goal to have balanced classes across each grade level. If you have specific information about your child that should be taken into consideration, please complete this form. We consider many factors as we try to stabilize our classes and accommodate individual needs:

- Gender balance
- Emotional/social combinations
- Balance of performance levels
- Special learning needs
- Teaching/learning styles
- Behavior factors

PHYSICAL AND HEALTH FACTORS

Consider: vision and hearing, speech, previous major illnesses, etc.

ACADEMIC INTERESTS AND ABILITIES

Consider: reading, writing, math, and science

EMOTIONAL AND BEHAVIORAL DEVELOPMENT

Consider: social awareness or interpersonal skills, cooperation, leadership, dependability, stability and respect for others.

SPECIAL AND/OR UNIQUE INFORMATION WHICH YOU THINK WOULD HELP US PLAN FOR YOUR CHILD – (What a teacher really needs to understand about your child.)

SIGNATURE _____

**Please return this form to your school on
Registration Night, Thursday, January 26, 2012
Thank you!**

Pupil Immunization Record

FOR SCHOOL USE ONLY

() Complete; booster required in _____

() In process; 8 mos. expires _____

() Medical exemption for _____

() Conscientious objection for _____

() Parental/guardian consent _____

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 (**see backside for exemption information**).

Parent: Enter the MONTH, DAY, and YEAR for all vaccines your child received OR **complete the exemption information on the backside**. DO NOT USE (✓) or (✗).

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	1st Dose	2nd Dose	3rd Dose	4th Dose	5th Dose
	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	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)					
Diphtheria and Tetanus (DT) • for 6-year-olds and younger					
Tetanus and Diphtheria (Tdap, Td) • for 7-year-olds and older					
Polio (IPV, OPV)					
Measles, Mumps, and Rubella (MMR) • minimum age: on or after 1st birthday • required for kindergarten and 7th grade					
Hepatitis B (hep B) • required for kindergarten and 7th grade					
Varicella (chickenpox) • minimum age: on or after 1st birthday • vaccine or disease history required for kindergarten and 7th grade					
Recommended:					
Meningococcal (MCV, MPSV)					
Human Papillomavirus (HPV)					
Hepatitis A (hep A)					

1. Choose one of the following to indicate student's immunization status and the source of the information above:

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

Signature of parent/guardian or physician/public clinic Date

B. I certify that this student has received at least one dose of vaccine for diphtheria, tetanus, and pertussis (if age-appropriate), polio, hepatitis B (K and 7th), varicella (K and 7th), 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

-OVER-

2. Parental/Guardian Consent:

Your child's school is asking your permission to share your child's immunization record with Minnesota's immunization registry to help us better protect students from disease. 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 record with Minnesota's immunization registry:

Signature of parent or legal guardian

Date

3. Exemptions to School Immunization Law

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.)

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

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

Additional exemptions:

- **Children less than 7 years of age:** The 5th dose of DTaP/DTP/DT (similarly, the 4th dose of polio vaccine) is not necessary if the 4th DTaP/DTP/DT (3rd dose of polio) was administered after the 4th birthday.
- **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 Td or Tdap booster at age 11 years or later is not required for students in grades 7-12 whose most recent Td was given after their 7th birthday but before their 11th birthday. Instead, it will be required 10 years after the date of the most recent dose.
- **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 10 years or older:** May receive Tdap to fulfill the Td requirement for students in grades 7-12.
- **Students 18 years of age or older:** Do not need polio vaccine.

**Edina Health Services
Kindergarten – 5th Grade
PHYSICAL EXAM / HEALTH HISTORY**

Name _____ Sex _____ Birth Date _____
 Address _____ Telephone _____
 Parent/Guardian Name _____ Parent/Guardian Name _____

TYPE of VACCINE	1 st DOSE MM/DD/YY	2 nd DOSE MM/DD/YY	3 rd DOSE MM/DD/YY	4 th DOSE MM/DD/YY	5 th DOSE MM/DD/YY
Diphtheria, Tetanus, Pertussis (DTaP, DTP)					
Diphtheria and Tetanus (DT)-for under 7 yrs					
Tetanus and Diphtheria (Td, Tdap)-for 7 yrs and older					
Polio (IPV, OPV)					
MMR (Measles, Mumps, Rubella) (minimum age: on or after 1 st birthday)					
Hepatitis B (Hep B)					
Varicella (chickenpox)					
HIB (Haemophilus Influenza b)					
Other (specify)					

HEALTH HISTORY

Communicable Diseases

- German Measles _____ (month & year)
- Mumps _____ (month & year)
- Red Measles _____ (month & year)
- Chickenpox _____ (month & year)

Identified Health Concerns

No Identified Health Concerns

- ADHD / ADD / other learning disability _____
- Allergies (describe) _____
- Asthma or other breathing problems (describe) _____
- Bladder problems / Bowel problems (describe) _____
- Diabetes: Type 1 Type 2 Managed by: Diet only Oral meds Insulin injections Insulin pump
- Heart Problems (describe) _____
- Seizures: Type (describe) _____
- No Identified Health Concerns

There is a condition that may result in an emergency: yes no (If yes, describe below.)

There is a condition that is being treated with medication: yes no (If yes, describe below.)

There is a condition that may interfere with learning: yes no (If yes, describe below.)

(over)

HEALTH EXAMINATION

	DATE	RESULTS
Hemoglobin/Hct		
Urinalysis		
Tuberculin (PPD)		mm
Chest x-ray		
Lead		

Height: _____ ins. Weight: _____ lbs. Blood Pressure ____ / ____ Hearing: ___ Normal ___ Abnormal Hearing aid(s): ___ yes ___ no Vision: R 20 / ___ L 20 / ___ Corrected ___ Yes ___ No

	Normal	Abnormal
Ears		
Mouth / Dental		
Throat		
Nose		
Lymph Nodes		
Thyroid		
Heart		
Pulses		
Lungs		
Abdomen		
Musculoskeletal		
Spine		
Extremities		
Skin		
Neurological		
Nutritional Status		
Emotional Status		
Behavior		
Speech		

Describe any abnormal findings / chronic conditions.

Health Concerns	Recommendations for School

Note: A separate medication form is required for all medications and treatments to be administered at school.

 Signature and title of health care provider Print name Date of physical exam

 Clinic name Phone FAX

Please return this form to your school nurse.

The school district intends to use the requested information to provide for your child's health and safety needs while at school. You may refuse to supply the requested personal information. There will be no consequence for not providing the information. 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, Subdivision2)