



PRIOR LAKE-SAVAGE  
AREA SCHOOLS

Please submit the enrollment packet to:

Paulette Noel

[pnoel@priorlake-savage.k12.mn.us](mailto:pnoel@priorlake-savage.k12.mn.us)

or mail it/drop it off to her attention at:

PLSAS District Services Center

Enrollment

4540 Tower St. SE

Prior Lake, MN 55372

Office Hours: M-F, 8 a.m. - 4 p.m.

PRIOR LAKE-SAVAGE AREA SCHOOLS ISD #719

STUDENT ENROLLMENT FORM

STUDENT INFORMATION											
LEGAL Last Name		LEGAL First Name		Middle Name		Birth Date		<i>(voluntary)</i> Is this student: Homeless Ward of the State Foreign Exchange Special Ed Active IEP ESL 504 Gifted/Talented			
Grade Entering	GENDER M F	Early Childhood Screening (age 2- 5) is required for entry into public school kindergarten. Has your child completed screening with ISD719? YES NO - in which District was your child screened									
Start Date											
Resident District <i>(if not Prior Lake- Savage Area Schools)</i>				If not a resident of ISD719, has an Open Enrollment Agreement been completed and approved?				YES NO			
Previous Schools Attended	Name of School			City		State		Dates			
FEDERAL DESIGNATIONS											
<u>Ethnicity:</u> <i>(state of MN Mandate)</i>  Is this student Hispanic/Latino?  <small>(Cuban, Mexican, Puerto Rican, South/Central American or other Spanish Culture or origin, regardless of race)</small>		YES NO		Home Language Questionnaire  First language learned by student?  Which language is most often spoken in home?  What language do the adults in the home speak?  Language normally used by student with friends?		ENGLISH		OTHER (SPECIFY)			
<u>Student's Race:</u> <i>(check all that apply)</i>  Amer. Indian/Alaska Native  Black or African American  Native Hawaiian/ Other Pacific Islander		Asian  White		Birth County if Born Outside of USA:  Date of entry to USA:  Date of first enrollment in USA school:				Has this student completed 3 or more years of school in the USA?  YES NO			
FAMILY INFORMATION											
Primary Household											
Address			City		State		Zip		Home Phone		
Primary Parent/Guardian #1 <i>(*Primary Contact for District Announcements)</i>				Primary Parent/Guardian #2							
Last Name		First Name		Last Name			First Name				
Middle Name		Relationship to Student		GENDER M F		Middle Name			Relationship to Student		
Email		Cell Phone					Email			Cell Phone	
		Work Phone								Work Phone	
Second Household											
Address			City		State		Zip		Home Phone		
Second Household Parent/Guardian #1 <i>(*Primary Contact for District Announcements)</i>				Second Household Parent/Guardian #2							
Last Name		First Name		Last Name			First Name				
Middle Name		Relationship to Student		GENDER M F		Middle Name			Relationship to Student		
Email		Cell Phone					Email			Cell Phone	
		Work Phone								Work Phone	
Siblings Under Age 21 in Home	Last Name		First Name		Middle Initial		Gender		Birth Date		

RES DIST # \_\_\_\_\_

ENTRY CODE \_\_\_\_\_

START DATE \_\_\_\_\_

STUDENT ID# \_\_\_\_\_

N

N

Y

Y

BIRTH CERTIFICATE

RE-ENROLL

N

Y

SCHOOL INITIALS

IMMUNIZATIONS

MARSS# \_\_\_\_\_



INDEPENDENT SCHOOL DISTRICT 719  
Prior Lake – Savage Area Schools

**NEW STUDENT FORM**

Last Revision 2016

Dear Parent/Guardian:

As part of your student's total education, personnel are available to work with your student if the need should arise.

Parents of students new to Independent School District 719 are asked to complete this form.

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_ Date \_\_\_\_\_

Has your student ever been expelled from a school? \_\_\_\_\_ If yes, when? \_\_\_\_\_

Has your student ever received help or service in any of the following areas of Special Education/Tutoring:

- |   |   |
|---|---|
| <input type="checkbox"/> Specific Learning Disabilities (SID)             | <input type="checkbox"/> Speech/Language (Speech) |
| <input type="checkbox"/> Emotional/Behavioral Disorders (E/BD)            | <input type="checkbox"/> Tutoring                 |
| <input type="checkbox"/> Mild/Moderate Mentally Handicapped (MMH)         | <input type="checkbox"/> Resource Room            |
| <input type="checkbox"/> Severe/Profound Mentally Handicapped (MSMH)      | <input type="checkbox"/> Hearing Impaired         |
| <input type="checkbox"/> Physical or Other Health Impaired (POHI or OHI)  | <input type="checkbox"/> Vision Impaired          |
| <input type="checkbox"/> Developmental/Adaptive Physical Education (DAPE) | <input type="checkbox"/> 504 Plan                 |
| <input type="checkbox"/> Other (Please Describe)                          |   |

If you checked any of the above, does your student have a current Individual Education Plan (IEP)?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

If no, what grade was service ended? \_\_\_\_\_

If known, name and phone number of last case manager/Special Education teacher:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Do you feel your student has any personal, learning or academic problems that should be discussed with a guidance counselor or Special Education Teacher?

\_\_\_\_\_ Yes \_\_\_\_\_ No (please describe): \_\_\_\_\_

Copies to: Cum Folder

Dean/Counselor



# PRIOR LAKE-SAVAGE AREA SCHOOLS

*A Community of Lifelong Learners*

**For office use only:**

- |                                   |                                 |
|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Academic | <input type="checkbox"/> ELL    |
| <input type="checkbox"/> Multiple | <input type="checkbox"/> Speech |
| <input type="checkbox"/> SpEd     | <input type="checkbox"/> Other  |
| <input type="checkbox"/> SPLIT    | _____                           |

## **STUDENT INFORMATION FORM**

Student Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Gender: M F  
(Last Name) (First Name)

Parent(s) Name: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work/Cell Phone Number: \_\_\_\_\_

Daycare your child will be attending (if any): \_\_\_\_\_

Identify some characteristics that describe your child to assist us in classroom assignments. The building administrator will use the information shared on this form to develop classroom assignments for the school year. Its purpose is **not** to identify a specific teacher. Teacher requests cannot be accepted.

My child works best in an \_\_\_\_\_ environment (Please describe – structured, more open, quiet, active, etc.).

My child may have needs in the areas of: (ex. Transitions from one activity to another, new people, speech, language development, etc.) Use reverse side, if necessary.

My child is reading independently. Yes No Independently read book title example: \_\_\_\_\_

*I understand that the total educational program must have the highest priority and the final determination of class assignments is the responsibility of the building principal. Factors for class placement include work habits, ability, special individual and building needs, and the balance of boys and girls.*

Parent/Guardian Signature \_\_\_\_\_



**Independent School District 719**  
**Prior Lake-Savage Areas Schools**  
4540 Tower Street SE  
Prior Lake, MN 55372

## AGE AND NAME VERIFICATION

This verification is needed BEFORE the student attends classes at Prior Lake-Savage Area Schools.

Prior Lake-Savage Area Public Schools require that all students initially entering or new to the school district provide documents verifying their birth date and legal name.

Documentation must be in the form of a certified birth certificate or current passport.

Your required signature to this form, as part of the registration process, indicates your awareness of the requirement and your commitment to provide the needed documentation.

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Signature of Parent/Guardian

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Date

Please note: If you cannot provide documentation immediately, please use this form as a reminder.



# PRIOR LAKE-SAVAGE AREA SCHOOLS EMERGENCY INFORMATION 2017-18

Student's Last Name		First	Middle
Male	Female	School	

Home Phone \_\_\_\_\_ Unlisted \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_ Graduation Year \_\_\_\_\_ Room # \_\_\_\_\_  
Month Day Year

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

**Parent or Guardian Information:** Write in extension or department at work when applicable

1. (Last name, First name) \_\_\_\_\_ Code \_\_\_\_\_ E-mail \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Ext. \_\_\_\_\_

Address, if different than student \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

2. (Last name, First name) \_\_\_\_\_ Code \_\_\_\_\_ E-mail \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Ext. \_\_\_\_\_

Address, if different than student \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

**Code Options**  
F = Father  
M = Mother  
G = Guardian  
SP = Step parent  
FP = Foster parent  
N = Neighbor  
GP = Grandparent  
FD = Friend  
SI = Sibling  
R = Relative  
D = Daycare

**List three emergency contacts who will assume temporary care of child if you cannot be reached.**

Name \_\_\_\_\_ Code \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Name \_\_\_\_\_ Code \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Name \_\_\_\_\_ Code \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

In case of serious accident or illness and I cannot be reached, I hereby authorize this Clinic \_\_\_\_\_ to give necessary treatment.

Clinic Phone (\_\_\_\_) \_\_\_\_\_ Insurance Carrier \_\_\_\_\_ Policy/Group # \_\_\_\_\_

Dentist \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Preferred Hospital: St. Francis Hospital-Shakopee \_\_\_\_\_ Fairview Ridges Hospital-Burnsville \_\_\_\_\_ Other: \_\_\_\_\_ Location: \_\_\_\_\_

## TO PARENT OR GUARDIAN:

The welfare of your child is our first consideration. In case of serious injury or illness of a student in school, our procedure is as follows **(due to variable nature of emergencies these steps/procedures are just guidelines and might be altered/omitted in the best interest of your child):**

1) The school nurse will be called. 2) If the nature of the illness/injury is severe and/or the parent/emergency contacts cannot be reached, **9-1-1** will be called and the student will be transported to the local clinic/emergency room as deemed most appropriate by the paramedics. Any charges incurred are the responsibility of the parent/guardian. 3) In the event school officials are unable to contact the parent(s)/guardian(s), the judgment of the doctor pertaining to the matter will govern. 4) In the event the parent(s)/guardian(s) do not want this procedure followed, a written notification expressing your wishes should be directed to the school nurse.

**There have been instances when we could not reach parents or guardians of injured or ill students because this form was not accurate. Please complete both sides of this form so we can keep our records up-to-date and initiate emergency care quickly. If there are any significant changes in your student's health, please keep the school nurse informed. It is the parent(s)/guardian(s) responsibility to make arrangements for proper care in case their child should meet with an accident or become too ill to remain in school at a time when the parent is away from home.**

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_

(page 1 of 2)

# ANNUAL HEALTH INFORMATION 2017-18

Student's Last Name

First

Middle

Grade

If your student has any condition which might result in an emergency during the school day - i.e., asthma, diabetes, bee sting allergy, severe food allergy, seizures, please request an Emergency Action Plan form from the school health office. Fill out the form and return to the office as soon as possible. All medications and treatments require signed authorization forms. If there is a health concern you prefer to discuss privately, please contact your school nurse.

Please check any conditions which apply to this student:

<input type="checkbox"/> Allergies (specify) _____ <input type="checkbox"/> Requires Emergency Plan or Accommodations at School <input type="checkbox"/> Bee Sting Allergy <input type="checkbox"/> Requires Epi-Pen at School <input type="checkbox"/> Requires Oral Meds at School <input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> <b>ASTHMA (EAP Required at School)</b> <input type="checkbox"/> Doctor Diagnosed <input type="checkbox"/> Uses Inhaler/Nebulizer <input type="checkbox"/> has had hospital visit within past 12 months for Asthma <input type="checkbox"/> Behavior Concerns (specify) _____ <input type="checkbox"/> <b>DIABETES (EAP Required at School)</b> <input type="checkbox"/> Dizzy/Fainting Spells (specify) _____ <input type="checkbox"/> Eczema/Chronic Rash <input type="checkbox"/> Emotional Concerns (specify) _____ <input type="checkbox"/> <b>EPILEPSY/SEIZURES (EAP Required at School)</b> <input type="checkbox"/> Frequent Colds <input type="checkbox"/> Sinus Infections <input type="checkbox"/> Frequent Earaches/Infections <input type="checkbox"/> PE Tubes in Place <input type="checkbox"/> Frequent Headaches (specify type/symptoms) _____ <input type="checkbox"/> Requires Medication at school <input type="checkbox"/> Hearing Problems (specify) _____ <input type="checkbox"/> Wears Hearing Aids <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both	<input type="checkbox"/> Heart Disease/Condition (specify) _____ <input type="checkbox"/> Orthopedic Concerns (specify) _____ <input type="checkbox"/> Serious Accident (specify) _____ <input type="checkbox"/> Surgery (specify/procedure/year) _____ <input type="checkbox"/> Special Diet (specify) _____ <input type="checkbox"/> Vision Concern <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Known Lazy Eye  <input type="checkbox"/> Currently Under Medical Care (specify) _____ <input type="checkbox"/> On Medication (specify) _____ <input type="checkbox"/> At Home <input type="checkbox"/> At School ( <b>Medication Form Required</b> ) <input type="checkbox"/> Physical Education Restrictions (specify) _____ <input type="checkbox"/> Special Education (specify) _____ <input type="checkbox"/> 504 <input type="checkbox"/> IEP <input type="checkbox"/> IFSP <input type="checkbox"/> Toileting/Personal Hygiene Concerns (specify) _____ <input type="checkbox"/> Other (specify) _____
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☐ NO new health concerns this year.

☐ NO new immunizations this year. ☐ Received new immunizations this year (Please submit on immunization form or copy from MD office.)

This information is confidential. Please initial the appropriate statement.

This information may ☐ may not ☐ be shared with school staff and transportation as deemed necessary by Health Services.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Physician (not required): \_\_\_\_\_ Date: \_\_\_\_\_

# Are Your Kids Ready?

## Minnesota's Immunization Law

### Immunization Requirements

Use this chart as a guide to determine which vaccines are required to enroll in child care, early childhood programs, and school (public or private).

Find the child's age/grade level and look to see if your child had the number of shots shown by the checkmarks under each vaccine. Children birth to age 2 may not have received all doses. Look at the table on the back, it shows the age when doses are due.

Birth through 4 years Early childhood programs & Child care	Age: 5 through 6 years <sup>①</sup> For Kindergarten	Age: 7 through 11 years For 1st through 6 <sup>th</sup> grade	Age: 12 years and older For 7 <sup>th</sup> through 12 <sup>th</sup> grade
Hepatitis A (Hep A) ✓✓			
Hepatitis B (Hep B) ✓✓✓	Hepatitis B ✓✓✓	Hepatitis B ✓✓✓	Hepatitis B <sup>⑥</sup> ✓✓✓
DTaP/DT ✓✓✓✓	DTaP/DT <sup>④</sup> ✓✓✓✓✓	✓✓✓tetanus and diphtheria containing doses	Tdap <sup>⑦</sup> ✓
Polio ✓✓✓	Polio <sup>⑤</sup> ✓✓✓✓	Polio ✓✓✓	Polio ✓✓✓
MMR ✓	MMR ✓✓	MMR ✓✓	MMR ✓✓
Hib ✓			Meningococcal <sup>⑧</sup> ✓ & booster
Pneumococcal <sup>②</sup> ✓✓✓✓			
Varicella <sup>③</sup> ✓	Varicella <sup>③</sup> ✓✓	Varicella <sup>③</sup> ✓✓	Varicella ✓✓

### Immunizations recommended but not required:

#### Influenza

Annually for all children age 6 months and older

#### Rotavirus

For infants

#### Human papillomavirus

At age 11 -12 years

- ① First graders who are 6 years old and younger must follow the polio and DTaP/DT schedules for kindergarten.
- ② Not required after 24 months.
- ③ If the child has already had chickenpox disease, varicella shots are not required. If the disease occurred after 2010, the child's doctor must sign a form.
- ④ Fifth shot of DTaP not needed if fourth was after age 4. Final dose of DTaP on or after age 4.
- ⑤ Fourth shot of polio not needed if third was after age 4. Final dose of polio on or after age 4.
- ⑥ An alternate 2-shot schedule of hepatitis B may also be used for kids from age 11 through 15 years.
- ⑦ Proof of at least three doses of diphtheria and tetanus vaccination needed. If a child received Tdap at age 7 through 10 years another dose of Tdap is not needed. Td does not meet the Tdap requirement.
- ⑧ One dose is required beginning at 7th grade. The booster dose is usually given at 16 years but the timing depends on when the first dose was given.

### Exemptions

To enroll in child care, early childhood programs, and school in Minnesota, children must show they've had these immunizations or file a legal exemption.

Parents may file a medical exemption signed by a health care provider or a conscientious objection signed by a parent/guardian and notarized.

### Looking for Records?

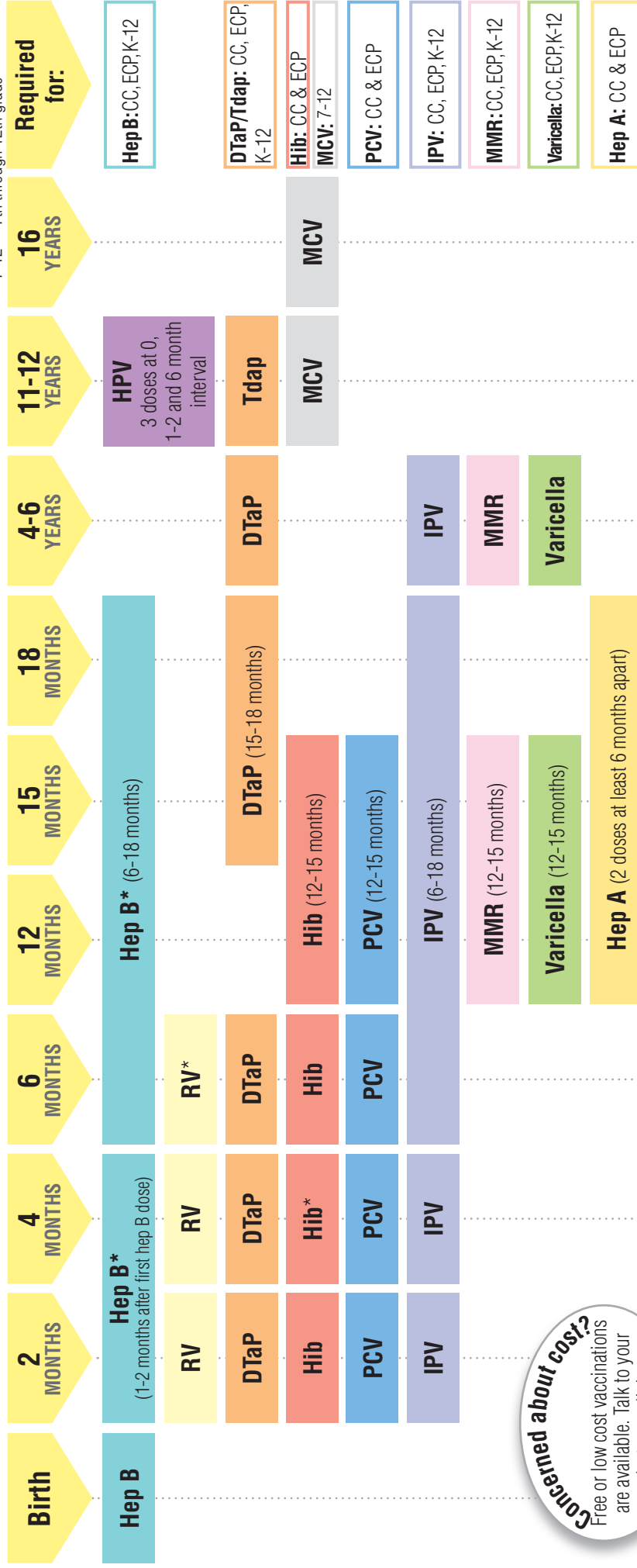
For copies of your child's vaccination records, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-5503 or 1-800-657-3970.



# When to Get Vaccines

## Birth to 16 Years

CC = Child care  
ECP = Early Childhood Programs  
K-12 = Kindergarten through 12th grade  
7-12 = 7th through 12th grade



**Concerned about costs?**  
Free or low cost vaccinations are available. Talk to your doctor or clinic.

**Influenza** (each fall)

It's not too late! If your child has fallen behind on their vaccinations, talk to your doctor or clinic to catch them up.

Minnesota law requires written proof of certain vaccinations for children in child care, early childhood programs, and school. However, if a child has a medical reason or if his/her parents are conscientiously opposed to any or all of the vaccinations, a legal exemption is available.

**Children with certain medical conditions may need additional vaccines** (e.g., pneumococcal or meningococcal). Talk to your doctor or clinic.

**Pregnant?** Protect yourself and your baby from whooping cough, get a Tdap vaccination between 27 and 36 weeks gestation. Talk to your doctor.

\*The **number of doses** depends on the product your doctor uses.

For copies of your child's **immunization records**, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-5503 or 1-800-657-3970.

Key to vaccine abbreviations

DTaP/Tdap=diphtheria, pertussis, tetanus	Hib = <i>Haemophilus influenzae</i> type b
Hep B=hepatitis B	IPV=polio
MMR= measles, mumps, rubella	PCV= pneumococcal
	RV=rotavirus

# 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

- ( ) Complete; booster required in \_\_\_\_\_  
 ( ) In process; 8 mos. expires \_\_\_\_\_  
 ( ) Medical exemption for \_\_\_\_\_  
 ( ) Conscientious objection for \_\_\_\_\_  
 ( ) 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
<b>Required</b> (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.)						
<b>Diphtheria, Tetanus, and Pertussis</b> (DTaP, DTP, DT) • for children age 6 years and younger • final dose on or after age 4 years						
<b>Tetanus and Diphtheria</b> (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 4rd dose was given on or after the 4th birthday	
<b>Tetanus, Diphtheria and Pertussis</b> (Tdap) • for children in 7th - 12th grade						
<b>Polio</b> (IPV, OPV) • final dose on or after age 4 years						
<b>Measles, Mumps, and Rubella</b> (MMR) • minimum age: on or after 1st birthday						
<b>Hepatitis B</b> (hep B)						
<b>Varicella</b> (chickenpox) • minimum age: on or after 1st birthday • vaccine or disease history required						
<b>Meningococcal</b> (MCV, MPSV) • for children in 7th - 12th grade • booster given at age 16 years						
<b>Recommended</b>						
<b>Human Papillomavirus</b> (HPV)						
<b>Hepatitis A</b> (hep A)						
<b>Influenza</b> (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.

**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

INDEPENDENT SCHOOL DISTRICT 719  
Prior Lake-Savage Area Schools

**Tennessen Notice for Student Registration Form**

As part of the registration process, you are being asked to provide information as to your child's age, residency, immunizations, expulsion status and general health. This information is being used by the School District for purposes of determining your child's eligibility for registration and transportation services by the School District. If you refuse to provide this information, your child will not be enrolled at the School District.

Other information requested in the registration packet is being collected to determine appropriate programming for your child, including his or her need for special education or related services and/or Limited English Proficiency services. The information provided also will be used by the School District to maintain contact with parents and/or guardians or those charged with the care of the student in case of emergency. Information also is solicited for the purpose of contacting a student's previous school to obtain education records in accordance with state law. You are not legally required to supply any of the requested data. However, if you fail to provide any of the data requested for these purposes, your application for registration may be delayed or placement and services may be affected.

Information pertaining to a child's race, color, creed, national origin, sex, or disability, is not collected for purposes of determining eligibility for registration. This data is requested for the purpose of compliance with state and federal law, including School District reporting obligations. You are not legally required to supply this data. However, failure to provide this information may affect the School District's ability to comply with state and federal laws and may reduce the funding the School District is otherwise eligible to receive to provide educational services.

Some of the data you provide, such as name, address, telephone number and date of birth, may be classified as directory information by the School District. The School District may provide such data to the public in accordance with School District Policy 515 – Student Records; unless you provide the required notice that you do not wish such data to be made public. A copy of the School District Policy 515 will be made available to you upon request. Any data which is not classified as directory information is considered private educational data and will not be released to the public. The data may, however, be shared with School District staff, other school districts, state or federal agencies, or other entities as required by state and federal law in accordance with Policy 515.

If you have any questions as to information solicited on the registration form, please contact the Assistant Superintendent of Schools at 952.226.0071



**NO ACTION IS REQUIRED** if you wish for your child to be included in the use of Information Technology, Google Apps for Education and iPads

**Student Use of Information Technology**

Policy 524 contains information regarding Student Use of Information Technology. Students are able to access the Internet from every classroom. Students also have access to Google Apps for Education. Students are expected to follow guidelines for acceptable use of the Internet and Student Code of Ethics Using Social Media. Should parents (or students age 18 or older) **NOT** want the following technologies to be used, this form must be completed and submitted to the ISD 719 Office of Information Technology, 4540 Tower St. SE, Prior Lake, MN 55372 or [smoore@priorlake-savage.k12.mn.us](mailto:smoore@priorlake-savage.k12.mn.us) **NO LATER THAN OCTOBER 1 EACH SCHOOL YEAR.**

☐ I **DO NOT** give permission for my child to have access to the Internet during the school day and request alternative educational activities not requiring Internet access.

☐ I **DO NOT** give permission for my child to have access to Google Apps for Education, including Chromebooks.

☐ I **DO NOT** give permission for my child to have access to an iPad or school-issued tablet.

Student Name \_\_\_\_\_  
(please print) \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Signature of Parent/Guardian (student if 18 or older)

\_\_\_\_\_

Print Parent/Guardian name (student if 18 or older)

\_\_\_\_\_

If you have checked any of the boxes above, this form must be returned by October 1  
of each school year to:

ISD 719 District Services Center, the Office of Information Technology  
4540 Tower Street SE, Prior Lake, MN 55372

- or -

[smoore@priorlake-savage.k12.mn.us](mailto:smoore@priorlake-savage.k12.mn.us) (contact for questions)

**If you choose to leave the above boxes blank, you are giving permission for your student to be included in the use of Information Technology, Google Apps for Education and iPads.**

## DENIAL OF RELEASE OF DIRECTORY INFORMATION

### Prior Lake-Savage Area Schools

In accordance with federal law and state statutes, the school board has defined Directory Information as listed below.

The following Directory Information will be released automatically for all students **UNLESS** the box below is checked to deny its release.

Directory Information includes:

- Student's name and address
- Telephone listing
- Date and place of birth
- Participation in officially recognized activities and sports
- Weight and height of members of athletic teams
- Dates of attendance
- Grade level
- Degrees or awards received
- Previous educational agency or institution attended
- Pictures for school-approved publications, electronic newsletters, cable TV or Newspapers
- Student pictures, video and artwork on district web pages, including district and school social media sites
- Names and pictures of students participating in or attending extra-curricular activities, school events, and High School League activities or events.

☐

### DENY RELEASE OF ALL DIRECTORY INFORMATION

*I understand that by denying the release of the above information, the affected student's name may not appear on some lists, such as honor rolls, athletic programs, yearbooks and graduation rosters.*

Signed \_\_\_\_\_ Address \_\_\_\_\_

Print Parent Name \_\_\_\_\_  
(Last Name) (First Name)

Date \_\_\_\_\_

Student Affected (please print) \_\_\_\_\_

Address \_\_\_\_\_

School Currently Attending \_\_\_\_\_

The designation of Directory Information about a student as private will remain in effect for one year or until it is modified by the written direction of the student's parent/guardian or the eligible student, whichever occurs first.

Return the completed and signed copy to Kristi Mussman in the Communications office, District Services Center, 4540 Tower Street SE, Prior Lake, MN 55372 or [kmussman@priorlake-savage.k12.mn.us](mailto:kmussman@priorlake-savage.k12.mn.us)