SCHOOL YEAR (SY) PROGRAM ENROLLMENT FORMS
REQUIRED FOR CURRENTLY ENROLLED
ECDC CHILDREN

**For ECDC filing purposes, please do not print 2-sided**

A child cannot begin the ECDC program unless all of the required forms have been completed and are on file in the ECDC office. Please mail or drop off your completed enrollment forms to:

ECDC
University of Notre Dame or
10 Child Care Center
Notre Dame, IN 46556

ECDC
Saint Mary’s College
Havican Hall
Notre Dame, IN 46556

1) The following is required for ALL children enrolled at ECDC-ND and is DUE JUNE 1ST. If your child is enrolled in the SU Program, you do not need to resubmit:

_____ Income Documentation – (ECDC-ND only) – Attach a signed copy of the first two pages of your most recent Federal Income Tax Return, Form 1040, to the ECDC Income Documentation Form.

2) The following are required annually for ALL children enrolled in the SY Program and are DUE AUGUST 1ST:

_____ Emergency Information & Medical Authorization Form

_____ General Information Form

_____ Emergency Health Information and Medical Plan Form – A physician’s signature is required in section 3 if your child has a medical condition or allergy requiring medications, restrictions, monitoring and/or food substitutions.

_____ SchoolMessenger Emergency Contact Information Form – Please complete and submit this form to ensure that you receive notifications of an emergency or closing as quickly as possible.

3) The following is required for SY Kindergarten children only and is DUE AUGUST 1ST:

_____ Preschool/Kindergarten/Child Care Center Health Record (Physical) Form – Must be completed by a physician; may be completed based on an appointment within the last 12 months; physical and immunizations must be up-to-date and on file within 30 days of enrollment.

4) Please complete the following if applicable:

- **Under-Immunized Agreement** – Please complete if your child is under-immunized due to a medical or religious exemption. **Obtain form from ECDC office.**

- **Menu Approval & Food Transport Form** – Please contact the ECDC office to schedule an appointment to review menus, discuss any substitutions and sign necessary paperwork if your child has a food allergy.
**INCOME DOCUMENTATION for ECDC-ND ONLY**

Summer Due Date: May 1st  
School Year Due Date: June 1st

The income based tuition fee schedule at the Early Childhood Development Center at Notre Dame (ECDC-ND) is based upon current combined family gross income. To be considered for the income based tuition fee schedule program, a copy of your most recent signed Federal Income Tax Return and this form must be completed and submitted to ECDC-ND by May 1 for the summer program and June 1 for the school year program.

If your most recent federal tax return does not reflect your current combined family income (larger or smaller), please provide an email or letter indicating the differences and 6 weeks of payroll summaries. If your family didn’t submit a federal tax return due to being a visiting professional, please provide your appointment letter that includes your salary.

The income based tuition fee schedule is available to ND and SMC staff, students, administration and faculty. *It is not available to ND and SMC Alumni(ae) and/or Holy Cross Order employees.* Those who elect not to provide income information/most recent tax return will be assessed the full tuition rate.

If your child is enrolled for both the summer and school year programs, only one submission of your Federal Income Tax Return with this form is required on or before May 1. Income based tuition eligibility is granted from the first day of the child’s enrollment in the summer program or the school year program, whichever occurs first, through the end of the school year. Verification of combined family gross income is required on an annual basis. If you have any questions, please contact Terri Kosik, Executive Director, at tkosik@saintmarys.edu or 631-3344. Please be assured that all income information will remain strictly confidential.

******************************************************************************

**Early Childhood Development Center - University of Notre Dame**

( ) I (we) am not eligible for the income based tuition fee schedule.

( ) I (we) am eligible but do not wish to apply for the income based tuition fee schedule.

( ) I (we) wish to apply for the income based tuition fee schedule for the Summer and/or the School Year Program(s) at ECDC-ND. (This does not apply to ECDC-SMC enrollment.) I (we) have attached a copy of my (our) most recent signed Federal Income Tax Return (first two pages) for review in determining program eligibility. (Please note – this is required for participation in the income based tuition schedule.)

( ) I (we) wish to apply for the income based tuition fee schedule for the Summer and/or the School Year Program(s) at ECDC-ND. I am submitting a letter of appointment because I do not file a U.S. Federal Tax Return.

Child’s (Children’s) Name(s): ____________________________________________

Parent Signature: _______________________________________________________

Date: __________________________________________________________________

Please submit this form and the first two signed pages of your Federal Tax Return by May 1 for summer or June 1 for school year.

Terri Kosik, Executive Director
Early Childhood Development Center
University of Notre Dame, 10 Child Care Center, Notre Dame, IN 46556
Fax: 574-631-7808 / Phone: 574-631-3344 / tkosik@saintmarys.edu
Name of Child ____________________________________________ Gender _______ Birthdate ____________________

Mother or guardian ____________________________________________ Home Phone __________________________

Home Address/City/State/Zip __________________________________________

Business Name __________________________ Occupation ____________________ Work Hours __________________

Business Address/City/State/Zip __________________________________________

Work Phone __________________________ Cell Phone* __________________________ E-mail* ___________________

Father or guardian ____________________________________________ Home Phone __________________________

Home Address/City/State/Zip __________________________________________

Business Name __________________________ Occupation ____________________ Work Hours __________________

Business Address/City/State/Zip __________________________________________

Work Phone __________________________ Cell Phone* __________________________ E-mail* ___________________

*Please note: The majority of ECDC letters and notices to families will be sent via e-mail.

ECDC will notify families of emergency school closures through School Reach Emergency Notification System via email, text & a recorded call to your cell phone. Please keep this information current with the ECDC office.

Important: Please indicate how you would like us to contact you during the school day regarding information about your child (injury, illness, etc.):

1st ____________________________ 2nd ____________________________ 3rd ____________________________

If either parent is a faculty member or student, please list school, department, and phone number of a secretary who would be able to reach you in an emergency:

School __________________________ Department ____________________ Phone ____________________

Please list the name of a friend or relative who may be reached in case of an emergency. This individual may be asked to pick your child up from ECDC in the event of an illness, injury or emergency. It is a State Requirement that a LOCAL emergency person is listed.

Name ____________________________________________ Relationship to child __________________________

Address/City/State/Zip __________________________________________ Phone ____________________

PERSONS AUTHORIZED TO PICK UP MY CHILD

Authorized individuals will be required to show picture identification when picking up a child from ECDC. Under no circumstances will a child be released to anyone not known to the center without authorization from parents or guardians.

1) Name ____________________________________________ Relationship to child __________________________

Address/City/State/Zip __________________________________________ Phone ____________________

2) Name ____________________________________________ Relationship to child __________________________

Address/City/State/Zip __________________________________________ Phone ____________________

If a parent is denied permission to pick-up a child or has restricted pick-up, please provide the parent's name and details - ____________________________________________________________ - and a copy of the court order.

Signature of Parent or Legal Guardian __________________________________________ Date ____________________
I agree, and by my signature give consent that in case of an accident, injury or illness of a serious nature, my child will be given emergency medical care. I understand that I will be contacted immediately, or as soon as possible, should I be away from the phone numbers given with this form.

Child’s Name _____________________________________________ Date of Birth____________________

Child’s Physician* ___________________________ Phone __________________________
Address/City/State/Zip________________________________________________________________________

Child’s Dentist* ___________________________ Phone __________________________
Address/City/State/Zip________________________________________________________________________

*If the name of a physician and/or dentist is not provided, the ECD consulting physician and/or dentist (Dr. John Rice, M.D., Dr. Deanna O’Neil, D.D.S.) will be listed for you until you provide an alternate physician and/or dentist.

If, in an emergency, your child’s regular doctor cannot be reached, may we use John Rice, M.D., the consulting physician for the Early Childhood Development Center? Yes_____ No _____ If you answered no, which other physician do you prefer we call?__________________________________________________________________
Address ___________________________________________________________________________________ Phone __________________________

Do you have a preference regarding the hospital we would take your child to in case of a medical emergency? Yes_____ No_____ If yes, please indicate your hospital of preference ________________________________________________

Name of child’s private health insurance & policy number:___________________________________________________
or
Medicaid or Hoosier Healthwise number for your child and primary adult______________________________

Signature of Parent or Legal Guardian_________________________________________ Date____________________

REMINDER: Please update information contained on this form when changes occur.
The information on this form is strictly confidential and will be used by the teacher to help her/him better understand and work with your child. (key: SY=school year, SU=summer)

Child’s Name_______________________________ Date of Birth _______________ Child’s Present Age____

What is the name you want on your child’s locker & cubbie? ____________________________________________________________

Family -
Father’s Name________________________________________ Mother’s Name________________________________________

Please list all children in the family and their ages______________________________________________________________

___________________________________________________________

Name of person(s) who has legal custody of child______________________________________________________________

Name of person(s) child lives with______________________________________________________________

If your child lives across two households, would you like duplicate items posted on your locker? Yes___No___

(SY only - Most communication will be via email, but picture order forms, fundraising materials, etc. will be posted on lockers)

Please list names of individuals (including emergency contacts) authorized by you or your family to have access to health information about this child ________________________________________________________________

_________________________________________________________________________________________________________

Please indicate your child’s ethnicity (this information is used for grant reporting purposes only):

☐ African American ☐ Native American/Alaska Native ☐ Asian ☐ Caucasian

☐ Pacific Islander/Native Hawaiian ☐ Latino ☐ Other ________________________

Child’s primary language ________________________________ Second language ______________________________

Does your child understand English? ________________________________________________________________

_________________________________________________________________________________________________________

Development and Information

Diet - Please check all that apply:

_____ My child is a vegetarian

_____ I would like my child to be served a vegetarian entrée for lunch

_____ Due to religious beliefs, my child does not eat ____________________________________________

_____ My child has dietary restrictions due to food allergies (a doctor’s signature is required on the medical plan form and please contact ECDC to arrange a time to review breakfast/lunch/snack menus)

My child receives/received special services (e.g., First Steps, Speech Therapy, OT, PT). Yes_____ No_____

If yes, please explain______________________________________________________________

_________________________________________________________________________________________________________

Pre-K only: Does your child nap?_____ If yes, how long and often?________________________ Does your child tire easily?______, please explain______________________________________________________________

_________________________________________________________________________________________________________
Toileting – for preschool ages only unless there is information you would like to share:

To what degree have bladder and bowel control been established?

Can your child help her/himself at the toilet?

Needs what kind of bathroom assistance?

Additional comments regarding toileting:

Past Experiences -

SU School Agers: What grade has your child finished? Your child’s school:

Has your child attended a recreational summer day camp program before?

Pre-K & Kindergarten: What type of program(s) has your child attended in the past?

Please describe your child’s overall reaction to group experiences

Describe your child in one or two words

Characteristic behavior in a new situation

Your child’s favorite activities and interests

Your child’s favorite books

Your child’s favorite indoor games

Your child’s favorite outdoor games

Describe any fears your child has of which we should be aware?

Parents’ methods of overcoming fears

SY only: In what ways would you like your child’s ECDC experiences to contribute to his/her growth and development?

Is there anything about your child that concerns you?

Have there been any unusual occurrences concerning your child that you feel we should be aware? (e.g. premature birth, auto accident, severe illness, death in the family, etc.)

Do you or your child have any special talents, interests, hobbies, or skills you could share with the children at ECDC?

SY only: Would you be available to help with special field trips? (applies to children enrolled in the 4’s, 4/5’s & kindergarten groups)

SY kindergarten only: What would be a convenient day of the week and/or time to visit the kindergarten class to share your talent, hobby, interest or career with the class?

Please feel free to attach an additional page if more space is needed to share any information that will help us better understand and work closely with your child and your family.
**ECDC CLASS DIRECTORY** – An ECDC class directory will be emailed to parents at the beginning of each semester and will include parents’ names, home addresses, home phone numbers and email addresses. We hope this directory is helpful as you schedule play dates and carpools. **The ECDC directory is compiled from the information you supplied on your registration form.**

_____ I give permission for my information to be included in the ECDC class directory.

_____ Our address has changed since we registered - please use the address on our emergency information form and not the address on the registration form.

_____ We prefer our cell phone numbers are listed on the directory rather than our home phone number.

Signature of Parent/Guardian ___________________________________________ Date ____________________

**ECDC PARENT HANDBOOK/TUITION** - I have read the ECDC Parent Handbook (available on the ECDC website at [http://www.nd.edu/~ecdcnd/parentsinfo.html](http://www.nd.edu/~ecdcnd/parentsinfo.html)) and understand the policies and procedures outlined within. I agree to follow the ECDC tuition policy on page 32 of the Parent Handbook and understand that tuition must be paid in advance.

Signature of Parent/Guardian ___________________________________________ Date ____________________

**DEVELOPMENTAL SCREENINGS** *(This applies to school year enrollment only)* – ECDC uses the Ages & Stages Developmental Screening (ASQs) to monitor children’s development when questions occur regarding learning or development. ASQs are administered by someone familiar to your child such as their ECDC teacher, program director or family resource specialist. The ASQ results are shared with parents in a confidential manner. I grant permission for my child to receive the ASQ Developmental Screening and/or ASQ Social Emotional (ASQ-SE) Developmental Screenings.

Signature of Parent/Guardian ___________________________________________ Date ____________________

**AUTHORIZATION TO SHARE HEALTH INFORMATION** – Early Childhood Development Center recognizes that health and medical information about your child is confidential. All records in your child’s file (including health, development and contact information) are kept in a locked cabinet in the office and access to this cabinet is limited. All information pertaining to the admission, development, assessment, family and/or discharge of a child is confidential and will only be shared with teachers and staff on a “need to know” basis.

By signing below, I give full time staff and teachers permission to have access to ______________________’s health records.

Signature of Parent/Guardian ___________________________________________ Date ____________________

**CHILD GUIDANCE/DISCIPLINE POLICY/COMMUNICATION** - I have read and/or discussed the Adlerian philosophy of teacher-child interactions and discipline implemented by the Early Childhood Development Center’s teaching staff. I understand that choices and logical consequences are utilized rather than punishment. Children are provided with encouragement rather than praise. According to state regulations, I understand that any disciplinary action taken will be communicated to the parents and noted in my child’s record. I also understand that I will be notified of all significant occurrences or problems which affect my child. This includes, but is not limited to, notices regarding accidents, injuries, first aid, possible exposure to communicable diseases and prior notification regarding field trips.

Signature of Parent/Guardian ___________________________________________ Date ____________________
PHOTOGRAPHY PERMISSION – I grant permission for photographs of my child to be taken at ECDC and possibly used in the following ways:

_____ for ECDC classroom use by teachers (to document learning and activities)
_____ for SMC/ND student projects (names will not be used)
_____ for media/marketing purposes (names will not be used)

Signature of Parent/Guardian_________________________________________ Date ______________________

SUNSCREEN PERMISSION (Parent Supplies) – I give permission for teachers to apply sunscreen to my child to help prevent possible sunburn. I understand that I must provide the sunscreen, and due to accreditation standards, I will provide a sunscreen that is a minimum SPF 15 and has UVA/UVB protection. ECDC staff will apply/or facilitate application of sunscreen as needed before outside activities (primarily May through September).

Signature of Parent/Guardian __________________________________________ Date ______________________

INSECT REPELLENT (ECDC Supplies) – I give permission for teachers to apply a mild insect repellant to my child prior to outdoor activities (e.g., nature activities/walks at parks such as Potato Creek Park, St. Mary’s College-Nature Walks, Madeline Bertrand Park, Bendix Park, Clay Park, Sarrett Nature Center, etc.). The insect repellant will be supplied by ECDC and will be applied by ECDC staff. Due to accreditation standards, the repellant used will contain DEET and will be applied no more than once per day.

Signature of Parent/Guardian __________________________________________ Date ______________________
# EMERGENCY HEALTH INFORMATION AND MEDICAL PLAN

**PART 1 - Parent or Guardian to Complete.**

<table>
<thead>
<tr>
<th>Student’s Name:</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Gender</th>
<th>DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>My child has a medical condition that may affect his or her school day</strong></td>
<td>☐ NO</td>
<td>☐ YES</td>
<td>(if YES, please complete Part 2, 3, 4)</td>
<td></td>
<td></td>
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<tr>
<td>Parent/Guardian’s Name (please print)</td>
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<tr>
<td>Parent/Guardian’s Signature</td>
<td>Date</td>
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**PART 2 – Complete all boxes that apply to your child.**

## ALLERGIES

- **Allergy type:**
  - Food
  - Medication
  - Bee sting
  - Other (list)

- **Reactions:**
  - Coughing
  - Hives
  - Rash
  - Difficulty breathing
  - Local Swelling
  - Wheezing
  - Generalized swelling
  - Nausea
  - Other

- **Currently prescribed treatments to be used IN SCHOOL**
  - Oral antihistamine (Benadryl, etc.)
  - EpiPen
  - Other

## ASTHMA

- **Triggers:**
  - Exercise
  - Environmental
  - Other (list)

- **Physical Restrictions:**
  - None
  - Self-limits
  - Other

- **Symptoms or reactions:**
  - Chest tightness/discomfort/pain
  - Difficulty breathing
  - Throat itch/tightness/soreness
  - Coughing
  - Hoarseness
  - Wheezing
  - Other

- **Currently prescribed treatments to be used IN SCHOOL**
  - Inhalers
  - Oral antihistamines
  - Oral steroids
  - Oral bronchodilator
  - Peak flow monitoring

- **Date of last hospitalization related to asthma**

## DIABETES

- **Currently prescribed treatments to be used IN SCHOOL**
  - Insulin
  - Syringe
  - Pen
  - Pump
  - Blood sugar testing
  - Glucagon

## SEIZURE DISORDER

- **Type of seizure:**
  - Absence (staring/unresponsive)
  - Complex partial
  - Generalized tonic-clonic (grand mal/convulsive)
  - Other (explain)
**SEIZURE DISORDER continued:**

<table>
<thead>
<tr>
<th>Physical restrictions:</th>
<th>NO</th>
<th>YES</th>
</tr>
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</table>

**Medications needed IN SCHOOL**

<table>
<thead>
<tr>
<th>Physical restrictions:</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
</table>

List medication(s) ______________________________________

Date of last seizure _______________________________

Length of seizure _______________________________

**OTHER HEALTH CONDITIONS**

<table>
<thead>
<tr>
<th>Physical condition (be specific)</th>
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<tbody>
<tr>
<td>Other (be specific)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical restrictions:</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
</table>

**Medications needed IN SCHOOL**

<table>
<thead>
<tr>
<th>Physical restrictions:</th>
<th>NO</th>
<th>YES</th>
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</table>

List medication(s) ______________________________________

**Special procedures required IN SCHOOL**

<table>
<thead>
<tr>
<th>Special procedures required</th>
<th>NO</th>
<th>YES</th>
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</table>

(explain) ____________________________________________

**VISION CONDITIONS**

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<tr>
<th>Contacts</th>
<th>Glasses</th>
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<tr>
<th>Other</th>
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**HEARING CONDITIONS**

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<th>Hearing aid(s)</th>
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<th>Other</th>
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**PART 3 – PHYSICIAN’S SIGNATURE REQUIRED if parent or guardian indicates medical condition(s) requiring medications, restrictions, monitoring and/or food substitutions.**

**Symptoms to watch for:**

When to use prescribed medication(s) (please list medication/dose/route):

When to call emergency health professional:

- This child has food allergies. Please allow parent/guardian to provide store bought substitutes as needed.

**Other notes:**

Physician’s signature ________________________________ Date ______________________

_Completed form may be faxed to ECDC-ND at 574-631-7808 or ECDC-SMC at 574-284-5344_

**PART 4 – EMERGENCY CONTACTS**

1. Call 911.
2. Dr. ___________________________ Phone Number: ___________________________
3. Parent/Guardian ___________________________ Phone Number: ___________________________
4. Parent/Guardian ___________________________ Phone Number: ___________________________
5. Emergency Contacts:
   Name/Relationship ___________________________ Phone Number(s)
   a. ___________________________ Phone Number(s)
   b. ___________________________ Phone Number(s)

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!**

Parent/Guardian’s Signature ___________________________ Date ______________________
School Messenger Emergency Contact Information

This school year ECDC has signed on with SchoolMessenger, a California-based company that provides notification services for emergency broadcasts from schools. The system is programmed to call the primary phone number of parents as well as send emails and texts to notify parents of an emergency closing due to a facility emergency (e.g., broken boiler in the winter resulting in no heat in the building) or a weather emergency (e.g., snow storm that inhibits teachers/staff from driving to ECDC).

To make sure our information is accurate and that we have the best email addresses and phone numbers for your family, we are asking that you fill out the attached form. This will ensure that you receive notifications of any emergency closings as quickly as possible. On the form below, please include any phone numbers you would like us to contact in the event of an emergency closing, as well as email addresses.

If you are interested in receiving the text notifications, you will also need to "opt in" with SchoolMessenger. Once we have updated SchoolMessenger, you should receive a text from 68453 asking you to text yes to receive text messages from ECDC. This step is required to receive emergency notifications via text message and is only required once. If you have "opted in" previously, this step will not be necessary. If you do not receive an "opt in" text, you do not have to wait for it to arrive before opting in, simply send yes to 68453 and you will receive a text back letting you know you have opted in for text messages.

Please print an email address and at least one phone number for each parent on the form below. If you have any questions about this form, please contact Nora Tudor at ncawley@saintmarys.edu or (574)631-3344.

Child’s Name: __________________________________________

Child’s Classroom: □ 2’s □ 3’s □ 3/4’s □ 4’s □ 4/5’s □ Kindergarten

ECDC Site: □ ECDC-ND □ ECDC-SMC

*Father’s Name: __________________________________________

*Father’s Email: __________________________________________

*Father’s Primary Phone #: ____________________________ □ Home # □ Cell #

Father’s Secondary Phone #: ____________________________ □ Home # □ Cell #

*Mother’s Name: __________________________________________

*Mother’s Email: __________________________________________

*Mother’s Primary Phone #: ____________________________ □ Home # □ Cell #

Mother’s Secondary Phone #: ____________________________ □ Home # □ Cell #

*required field
*All child physicals must be submitted to the office no later than 30 days after their first day of enrollment.

<table>
<thead>
<tr>
<th>Name of child (last, first)</th>
<th>Date of birth (month, day, year)</th>
<th>Date of admission (month, day, year)</th>
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<tr>
<th>Address (number and street, city, state, ZIP code)</th>
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<table>
<thead>
<tr>
<th>Child lives with (relationship)</th>
<th>Name</th>
<th>Telephone number ( )</th>
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### MEDICAL HISTORY

<table>
<thead>
<tr>
<th>Communicable Disease</th>
<th>Month / Year</th>
<th>Condition</th>
<th>Explain if present</th>
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<tbody>
<tr>
<td>Measles</td>
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<tr>
<td>Rubella (German Measles)</td>
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<tr>
<td>Chickenpox</td>
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<td>Mumps</td>
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<tr>
<td>Scarlet Fever</td>
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<tr>
<td>Whooping Cough</td>
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<tr>
<td>Other:</td>
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### PHYSICAL EXAMINATION

<table>
<thead>
<tr>
<th>Date of exam (month, day, year)</th>
<th>Age of child</th>
<th>Skin</th>
<th>Heart</th>
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<thead>
<tr>
<th>Lymphnodes</th>
<th>Lungs</th>
<th>Eyes</th>
<th>Abdomen</th>
<th>Ears</th>
<th>Genitalia</th>
<th>Nasopharynx</th>
<th>Teeth and Mouth</th>
<th>Other:</th>
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Note any unusual findings:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Does this child have any health condition that would be hazardous either to the child or to the other children in a group setting as a result of participation in normal activities (including sports)?

☐ Yes ☐ No

If yes, what modification of normal activities would be necessary to protect the child and the child’s classmates:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Have you prescribed any medications or special routines which should be included in the center’s plans for this child’s activities?

☐ Yes ☐ No

If yes, please explain:

________________________________________________________________________

________________________________________________________________________

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## HISTORY OF IMMUNIZATIONS

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>(Enter the month, day and year each immunization was given.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP/DT*</td>
<td>Diphtheria, Tetanus, Pertussis</td>
</tr>
<tr>
<td>Hib</td>
<td>Haemophilus influenza type b</td>
</tr>
<tr>
<td>IPV*</td>
<td>Polio</td>
</tr>
<tr>
<td>MMR*</td>
<td>Measles, Mumps, Rubella</td>
</tr>
<tr>
<td>Varicella*</td>
<td>Or Chickenpox Disease (Month/Year):</td>
</tr>
<tr>
<td>PCV*</td>
<td>Pneumococcal Conjugate</td>
</tr>
<tr>
<td>Hep B*</td>
<td>Hepatitis B</td>
</tr>
<tr>
<td>Hep A**</td>
<td>Hepatitis A</td>
</tr>
<tr>
<td>RGE</td>
<td>Rotavirus</td>
</tr>
<tr>
<td>Flu</td>
<td>Influenza</td>
</tr>
</tbody>
</table>

## ADDITIONAL NOTES AND INSTRUCTIONS

*Indiana law requires all children attending licensed childcare facilities to be immunized against this disease.*  
**Hep A is required for kindergarten enrollment.**

## STATEMENT OF EXEMPTION TO IMMUNIZATION LAW

IN THE EVENT THAT A VACCINE-PREVENTABLE DISEASE TO WHICH CHILDREN ARE SUSCEPTIBLE OCCURS IN THE PROGRAM, UNDER-IMMUNIZED CHILDREN WILL BE PROMPTLY EXCLUDED PER STATE GUIDELINES. (ECDC tuition continues during exclusion)

**MEDICAL EXEMPTION:** The physical condition of the above named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.

Signed ______________ Date ______________

Medical exemption to the following vaccine(s):

- [ ] DTaP
- [ ] IPV
- [ ] MMR
- [ ] VAR
- [ ] PCV
- [ ] HepB
- [ ] Hep A

**RELIGIOUS EXEMPTION:** Parent or guardian of the above named person or the person himself/herself is an adherent to a religious belief opposed to immunizations.

Signed ______________ Date ______________

Religious exemption to the following vaccine(s):

- [ ] DTaP
- [ ] IPV
- [ ] MMR
- [ ] VAR
- [ ] PCV
- [ ] HepB
- [ ] Hep A

**Name of physician / nurse practitioner completing form (please print)***

**Signature of physician / nurse practitioner**

Completed forms may be faxed to:

**ECDC at Notre Dame**  
Phone: (574) 631-3344  
Fax: (574) 631-7808

**ECDC at Saint Mary’s**  
Phone: (574) 284-4693  
Fax: (574) 284-5344