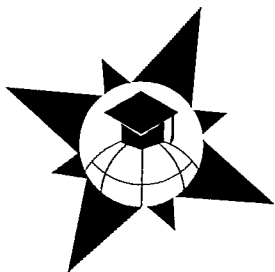


APPLICATION
2021-22 School Year



Career Pathways Public Charter Secondary School
Phone: 651-400-1781
Fax: 651-400-1782

Student Name: _____ ****Entering Grade:** _____

Please print neatly

Parent/Guardian Name (s): _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Parent/Guardian Phone: _____

Parent/Guardian Email Address: _____

Student Phone: _____

Student Email Address: _____

Student Date of Birth: _____

Sibling Name/Grade: _____

Due to sibling enrollment preference required by Minnesota Law, Career Pathways asks that you identify siblings who are concurrently applying for admission at Career Pathways. All siblings must have a separate form.

* Parent Signature: _____

By signing this form I give permission for student records to be requested from the previous school for enrollment.

I understand that providing false or inaccurate information will void this application and the spot will be given to the next child on the waitlist.

If we receive more applications than there are spaces; students are placed on a waiting list and/or may be a part of a lottery.

Director's Signature

Date

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

For Office Use

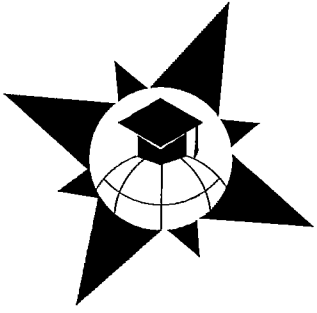
Included in Lottery? Y/N

Enrolled? Y/N Grade: _____

Date Received: _____

Please send applications to: Career Pathways, 1355 Pierce Butler Rt., St. Paul, MN 55104

OFFICE DRIVE



Student Name:
Grade:

Outings/Field Trips/Transportation Release

I understand that an important and regular part of the school program includes outings into the community and frequent field trips and field experiences. I understand that these trips may utilize public transportation accompanied by volunteer parents and/or school staff. I also understand that students will engage in walking trips in and around the community accompanied by volunteer parents and/or school staff. I give my permission for my child to participate in these trips.

I acknowledge that participation in Field Trips involves some risk of physical injury. I have been informed of and agree to expressly accept and assume any and all risk of injury or sickness arising from such participation. I recognize that Career Pathways does not carry health or accident insurance or other insurance for medical hospitalization expenses arising from such injuries or sickness. In consideration of participating in Field Trips, we hereby agree to waive, release, and forever discharge Career Pathways, its officers, directors, sponsors and employees from any and all liability from the participation in this activity.



Parent Signature

Date

Ethnic and Racial Demographic Designation Form

Student's First Name: _____ Middle Name/Initial: _____ Last Name: _____
 Date of Birth: _____ District: 4237 School: CAREER PATHWAYS

Schools are required to report ethnicity and race to the state and to the U.S. Department of Education. Because of recent changes to Minnesota state law, Minnesota disaggregates each category into detailed groups to further represent our student populations. Parents or guardians are not required to answer the federal questions (**in bold**) for their children. If you choose not to answer the federal questions (**in bold**), federal law requires schools to choose for you. This is a last resort—we prefer if parents or guardians complete the form. State questions are labeled as "Optional" and schools will not fill in this information for you.

This information helps improve teaching and learning for everyone and helps us accurately identify and advocate for students currently underserved. The information this form collects is considered private information. You can review the privacy notice to learn more about the purpose of collecting this information, how it will be used and not used, and how the detailed groups were identified. The privacy notice can be found in our *Frequently Asked Questions: Ethnic and Racial Designation Form*.

Is the student Hispanic/Latino as defined by the federal government? The federal definition includes persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.¹

[You must select "yes" or "no" to this question.]

Yes *[If yes, go to Question A.]*

No *[If no, go to Question 1.]*

Optional Question A: If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

- | | | | |
|--|---------------------------------------|--|--|
| <input type="checkbox"/> Decline to indicate | <input type="checkbox"/> Guatemalan | <input type="checkbox"/> Salvadoran | <input type="checkbox"/> Other Hispanic/Latino |
| <input type="checkbox"/> Colombian | <input type="checkbox"/> Mexican | <input type="checkbox"/> Spaniard/Spanish/
Spanish-American | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Ecuadorian | <input type="checkbox"/> Puerto Rican | | |

Go to Question 1.

[Select "yes" to at least one of the Questions (1-6) below.]

Question 1: Does the student identify as American Indian or Alaska Native as defined by the state of Minnesota? The state of Minnesota definition includes persons having origins in any of the original peoples of North America who maintain cultural identification through tribal affiliation or community recognition. [This question is needed to calculate state aid/funding.]

Yes *[If yes, go to Question 1a.]*

No *[If no, go to Question 2.]*

Optional Question 1a: If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

- | | | |
|--|--|---|
| <input type="checkbox"/> Decline to indicate | <input type="checkbox"/> Cherokee | <input type="checkbox"/> Other North American Indian Tribal Affiliation |
| <input type="checkbox"/> Anishinaabe/Ojibwe | <input type="checkbox"/> Dakota/Lakota | <input type="checkbox"/> Unknown |

Go to Question 2.

¹Federal Register, Vol. 72, No. 202/Friday, October 19, 2007/Notices/59274

Question 2. Is the student American Indian from South or Central America?

Yes [Go to Question 3.]

No [Go to Question 3.]

Question 3. Is the student Asian as defined by the federal government? The federal definition includes 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, the Philippine Islands, Thailand, and Vietnam.¹

Yes [If yes, go to Question 3a.]

No [If no, go to Question 4.]

Optional Question 3a. If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

Decline to indicate

Chinese

Karen

Other Asian

Asian Indian

Filipino

Korean

Unknown

Burmese

Hmong

Vietnamese

Go to Question 4.

Question 4. Is the student black or African American as defined by the federal government? The federal definition includes persons having origins in any of the black racial groups of Africa.¹

Yes [If yes, go to Question 4a.]

No [If no, go to Question 5.]

Optional Question 4a. If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

Decline to indicate

Ethiopian-Other

Somali

African-American

Liberian

Other black

Ethiopian-Oromo

Nigerian

Unknown

Go to Question 5.

Question 5. Is the student Native Hawaiian or Other Pacific Islander as defined by the federal government? The federal definition includes persons having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.¹

Yes [Go to Question 6.]

No [Go to Question 6.]

Question 6. Is the student white as defined by the federal government? The federal definition includes persons having origins in any of the original peoples of Europe, the Middle East, or North Africa.¹

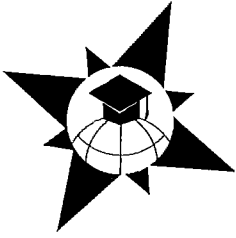
Yes

No

Parent(s)/Guardian Name _____ Date _____

* Parent(s)/Guardian Signature _____

Intake Interview



1. Student Information

Last Name: _____ First Name: _____

Expected grade level at time of enrollment: _____

Identifies with: Male Female

2. Immigration Status

Birth Country: _____

Immigrant From: _____

Immigration Date: _____

3. Homeless Status

Does student have a permanent place to stay? Yes or No

If no, where does student most often stay? _____

4. Services received at previous school? (Mark all that apply.)

- Special Education
- English as second language support
- Other: _____

5. Schools Attended (most recent first; use reverse as needed):

Name of School	Grade(s)	Dates

6. Is the student interested in bus transportation? Yes or No (circle one)

Completed By: _____

Date: _____

Minnesota Language Survey

Minnesota is home to speakers of more than 100 different languages. The ability to speak and understand multiple languages is valued. The information you provide will be used by the school district to see if your student is multilingual. In Minnesota, students who are multilingual may qualify for a Multilingual Seal upon further assessment. Additionally, the information you provide will determine if your student should take an English proficiency test. Based upon the results of the test, your student may be entitled to English language development instruction. **Access to instruction is required by federal and state law. As a parent or guardian, you have the right to decline English Learner instruction at any time.** Every enrolling student must be provided with the Minnesota Language Survey during enrollment. Information requested on this form is important to us to be able to serve your student. Your assistance in completing the Minnesota Language Survey is greatly appreciated.

Student Information	
Student's Full Name: (Last, First, Middle)	Birthdate or Student ID:

	Check the phrase that best describes your student:	Indicate the language(s) other than English in space provided:
1. My student first learned:	<input type="checkbox"/> language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> only English.	
2. My student speaks:	<input type="checkbox"/> language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> only English.	
3. My student understands:	<input type="checkbox"/> language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> only English.	
4. My student has consistent interaction in:	<input type="checkbox"/> language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> only English.	

Language use alone does not identify your student as an English learner. If a language other than English is indicated, your student will be screened for English language proficiency.

Parent/ Guardian Information	
Parent/Guardian Name (printed):	
Parent/Guardian Signature:	Date:

* All data on this form is private. It will only be shared with district staff who need the information to best serve your student and for legally required reporting about home language and service eligibility to the Minnesota Department of Education. At the district and at the Minnesota Department of Education, this information will not be shared with other individuals or entities, except if they are authorized by state or federal law to access the information. Compliance with this request for information is voluntary.

* Please complete and sign page 3 😊

Instructions for Completing the Alternate Application for Educational Benefits

Complete the *Alternate Application for Educational Benefits* for school year 2021-22 if any of the following apply:

Any household member currently participates in the Minnesota Family Investment Program (MFIP), or

The Supplemental Nutrition Assistance Program (SNAP), or the Food Distribution Program on Indian Reservations (FDPIR), or

One or more children in the household are foster children (a welfare agency or court has legal responsibility for the child), or

Total household income (gross earnings, not take-home pay) is within these guidelines:

Maximum Total Income

Household Size	\$ Per Year	\$ Per Month	\$ Twice Per Month	\$ Per 2 Weeks	\$ Per Week
1	23,828	1,986	993	917	459
2	32,227	2,686	1,343	1,240	620
3	40,626	3,386	1,693	1,563	782
4	49,025	4,086	2,043	1,886	943
5	57,424	4,786	2,393	2,209	1,105
6	65,823	5,486	2,743	2,532	1,266
7	74,222	6,186	3,093	2,855	1,428
8	81,621	6,886	3,443	3,178	1,589
Additional	8,399	700	350	324	162

Children and Foster Status: List all children in the household in Section 1.

- Indicate that a child is in foster care by checking the box.
- Include any regular income, for example supplemental security income (SSI), to children other than foster children. Do not list occasional earnings like babysitting.

Case Number: Complete Section 2 if any household member currently participates in one of the programs listed in that section. If Section 2 is completed, skip Section 3 (adult names and incomes).

Adults/Household Incomes: List all adult household members, whether related or not, in Section 3. Include an adult who is temporarily away, such as a student away at college. Do not complete Section 3 if a case number was provided in Section 2, or if the application is for foster children only.

List each adult household member's gross incomes (not take-home pay) and how often each income is received. For example, "W" for Weekly.

- List gross incomes before deductions.
- If an income varies, list the amount usually received.
- For farm/self-employment income only, list net income after subtracting business expenses.
- Examples of "other income" to include in the last column are farm/self-employment, Veterans benefits and disability benefits.
- Check the "No Income" column after a person's name if they have no income.

Do not include as income: foster care payments, federal education benefits, MFIP payments, combat pay, or value of assistance received from SNAP, WIC, FDPIR or Military Privatized Housing Initiative.

Signature: The form must be signed and dated by an adult household member in Section 5.

Alternate Application for Educational Benefits School Year 2021-22 State and Federally Funded Programs

Economic Status for MARSS Reporting: Community Eligibility Provision 2 and 3 No Meal Program

1. Names of all Children in Household including Foster Children. Attach additional page if necessary.

Last Name	First Name	Date of Birth (MM/DD/YYYY)	Grade	School	Check if Foster Child	Any Regular Income to Child Example SSI
						\$ per
						\$ per

1. Benefits (if applicable)

If any household member receives benefits from a program listed below, write in the name of the person and case number, check the appropriate box, and skip Section 3.

Name: _____ Case Number: _____

Minnesota Family Investment Program (MFIP) Supplemental Nutrition Assistance Program (SNAP) Food Distribution Program on Indian Reservations
Medical Assistance and WIC do not qualify.

Child is the legal responsibility of a welfare agency or court. (If all children applied for are foster children, skip Sections 3 and 4.)

2. Names of all Adults in Household (all household members not listed in Section 1).

Include all adults living in your household, related or not. Attach an additional page if necessary.

Names of All Adult Household Members (First and Last)	
List all Household members not listed in STEP 1 (including yourself) even if they do not receive income. Include children who are temporarily away at school or in college.	

Gross Earnings from Working at Jobs	Report income before deductions or taxes in whole dollars (no cents).		
	Weekly	Bi-Weekly	Monthly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are you Self-Employed or a Farmer?	Net income from Farm or Self-Employment. Do not duplicate elsewhere.	
	Monthly	Yearly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>


Any Other Gross Income	SS, Unemployment, Public Assistance, Child Support, and others on Page 2	
	Weekly	Monthly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Household Incomes: Write in each gross income and how often it is received: **weekly (W)**, **bi-weekly (every two weeks) (BW)**, **twice per month (TM)**, **monthly (M)**. Do not write in hourly pay. If income fluctuates, write in the amount normally received. Attach an additional page if necessary.

3. This information may be shared with Minnesota Health Care Programs to identify children who are eligible for Minnesota health insurance programs. Leave the box blank to allow sharing of information. See page 3 for more information.

Do not share information with Minnesota Health Care Programs.

I certify (promise) that all information furnished on this application is true and correct, that all household members and incomes are reported, that application is made so that the school may receive state funds based on the information on the application, that school officials may verify the information on the application, and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal criminal statutes.

 Signature of Adult Household Member (required): _____ Date: _____

Print Name: _____ Home Phone: _____ Work Phone: _____

Address: _____ City: _____ ZIP: _____

Office Use Only

Total Household Size: _____ Total Income: \$ _____ per _____

Approved (check all that apply): Case Number – Free Foster – Free Income – Free Income – Reduced-Price

Denied: Incomplete Income Too High Other: _____

Signature – Determining Official: _____ Date: _____

Change Status To: _____ Reason: _____ Withdrawn: _____

Office Use Only

Date Verification Sent: _____ Response Due: _____ Second Notice: _____

Result: Free to Reduced-Price Free to Paid Reduced-Price to Free Reduced-Price to Paid

Reason for Change: Income Case number not verified Foster not verified Refused Cooperation Other

Signature Verifying Official: _____ Date: _____

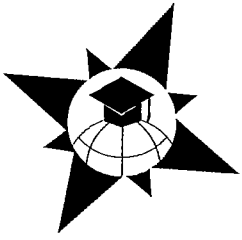
Signature Confirming Official: _____ Date: _____

Privacy Act Statement/How Information Is Used

We will use your information to determine if your child is eligible for free or reduced-price economic status for purposes of state reporting. We may share your eligibility information with education, health, and nutrition programs to help them evaluate, fund or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

At public school districts, each student's economic status is also recorded on a statewide computer system used to report student data to the Minnesota Department of Education as required by state law. The Minnesota Department of Education uses this information to: (1) administer state and federal programs, (2) calculate compensatory revenue for public schools; and, (3) judge the quality of the state's educational program.

Children who are eligible for free and reduced-price economic status may be eligible for Minnesota Health Care Programs. Your child's eligibility status may be shared with Minnesota Health Care Programs, unless you tell us not to share your information by checking the box in Section 4 of the application. You are not required to share information for this purpose and your decision will not affect your child's economic status as determined on this for.



Student Health Profile

Student Name: _____

Grade: _____

Emergency Contact

Name	_____	Relationship	_____
Primary Phone	_____	Other Phone	_____

Name	_____	Relationship	_____
Primary Phone	_____	Other Phone	_____

Physician/Doctor	_____	Phone	_____
------------------	-------	-------	-------

Health Conditions

Condition	Start Date	Comment

Allergies	_____
Recent surgery, accident, or illness?	_____

Does the student take daily medication? Yes No

If yes, please specify: _____

I, the undersigned parent/guardian, give my consent for the above named child to be released to me or my spouse or to the emergency contact I have designated above, and/or to be taken by ambulance to the nearest hospital in case of emergency.

I understand that Career Pathways does not provide accident medical/dental coverage for students for injuries/illnesses occurring at school. I further acknowledge **that I am financially responsible for medical, dental, ambulance, or other health care expenses** or transportation of my child home, which might occur as a result of such illness or injury.



Parent Signature

Date



**Administration of School Supplied Acetaminophen (Tylenol)
and Antacid for Middle School and High School Students**

Purpose: Over the counter (OTC) pain relief medications can be obtained without a doctor's prescription and are used for the relief of pain symptoms on a temporary basis. Appropriate use of over the counter pain relief medications at school can assist students to remain in school and continue to achieve in the classroom. The American Academy of Pediatrics Policy Statement for Administration of Medication in School states "providing parent approved short-term medications, such as pain relievers, may provide symptomatic improvement for the student, which enables attendance for learning and causes less classroom disruption."

Valid for current school year 21-22

Student name: _____ **Date of birth:** _____ **Grade:** _____

I give permission to authorized school staff to give my child acetaminophen (Tylenol) and Antacids when determined to be needed for stomach ache, nausea, headache, menstrual cramps or tooth/orthodontic pain. The student will be able to receive 5 doses throughout the school year. When 5 doses have been given the parent will be notified.

Select a medication and dose to be given

Acetaminophen (Tylenol) 500mg tablets- give 1 or 2 (circle) tablets

Anti Acid - give 1 or 2 (circle) tablets

Does this student have any drug allergies? List _____

Does this student have any chronic health conditions? List _____

Date	Time	Medication	Dosage	Reason or need for Medication	Initials

* **Parent/guardian signature** _____ **Date** _____

School health secretary signature _____ **Date** _____

Immunization Form

Name _____

Birthdate _____

Immunizations required for child care, early childhood programs, and school.

Birth to 6 months

12 -24 months

At Kindergarten

At 7th grade

At 12th grade

Vaccine

Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Haemophilus influenzae type b (Hib)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumococcal (PCV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Measles, Mumps, Rubella (MMR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chickenpox (varicella)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus, Diphtheria, Pertussis (Tdap)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meningococcal (MCV4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Minnesota law requires children enrolled in child care, early childhood education, or school to be immunized against certain diseases, unless the child is medically or non-medically exempt.

Instructions for parent or guardian:

- Fill out the dates in chronological order even if your child received a vaccine outside of the age/grade category that the box is in. Depending on the age of your child, they may not have received all vaccines; some boxes will be blank.
 - If you have a copy of your child's immunization history, you can attach a copy of it instead of completing the front of this form.
 - Your doctor or clinic can provide a copy of your child's immunization history. If you are missing or need information about your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-3980 or 800-657-3970.
- Sign or get the signatures needed for the back of this form.
 - Document medical and/or non-medical exemptions in section 1.
 - Verify history of chickenpox (varicella) disease in section 2.
 - Provide consent to share immunization information (optional) in section 3.

*** HAVE YOUR DOCTOR FAX YOUR RECORDS TO US**

651-400-1782 Thank You

CAREER PATHWAYS



Immunization Program (2019)
www.health.state.mn.us/immunize

Instructions: Complete section 1 to document a medical or non-medical exemption, section 2 to verify history of varicella disease, and section 3 to consent to share immunization information.

Name _____

1. Document a medical and/or non-medical exemption (A and/or B).

Place an X in the box to indicate a medical or non-medical exemption. If there are exemptions to more than one vaccine, mark each vaccine with an X.

Vaccine	Medical Exemption	Non-Medical Exemption
Diphtheria, Tetanus, and Pertussis		
Polio		
Measles, Mumps, Rubella		
<i>Haemophilus influenzae</i> type b		
Chickenpox (varicella)		
Pneumococcal		
Hepatitis A		
Hepatitis B		
Meningococcal		

B. Non-medical exemption: A child is not required to have an immunization that is against their parent or guardian's beliefs. However, choosing not to vaccinate may put the health or life of your child or others they come in contact with at risk. Unvaccinated children who are exposed to a vaccine-preventable disease may be required to stay home from child care, school, and other activities in order to protect them and others.

By my signature, I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs. I am aware that my child may be required to stay home from child care, school, and other activities if exposed.

Signature: _____ Date: _____
(of parent or guardian in presence of notary)

Non-medical exemptions must also be signed and stamped by a notary:

This document was acknowledged before me on _____ (date) _____
by _____ (name of parent or guardian)

Notary Stamp
STATE OF MINNESOTA, COUNTY OF _____

Notary Signature: _____

A. Medical exemption: By my signature below, I confirm that this child should not receive the vaccines marked with an X in the table for medical reasons (contraindications) or because there is laboratory confirmation that they are already immune.

Signature: _____ Date: _____
(of health care practitioner*)

2. History of chickenpox (varicella) disease. This child had chickenpox in the month and year _____

My signature below means that I confirm that this child does not need chickenpox vaccine because:

- I am a health care practitioner and this child was previously diagnosed with chickenpox or the parent provided a description that indicates this child had chickenpox in the past.
- I am the parent or guardian and this child had chickenpox on or before September 1, 2010.

Signature: _____ Date: _____
(of health care practitioner*, representative of a public clinic, or parent/guardian). Parent can sign if chickenpox occurred before September 2010.

*Health care practitioner is defined as a licensed physician, nurse practitioner, or physician assistant.

Signature: _____ Date: _____
(of parent/guardian)

3. Consent to share immunization information: This school is asking for permission to share your child's immunization record with Minnesota's immunization information system. Giving your permission will:

- Provide easier access for you and your school to check immunization records, such as at school entry each year.
- Support your school in helping to protect students by knowing who may be vulnerable to disease based on their immunization record. This can be important during a disease outbreak.

Under Minnesota law, all the information you provide is private and can only be released to those authorized to receive it. Signing this section of the form is optional. If you choose not to sign, it will not affect the health or educational services your child receives.

I agree to allow my child's school to share my child's immunization documentation with Minnesota's immunization information system: