4-Year-Old School Readiness Preschool Enrollment Forms
500 Highway 23 West, Milaca, MN 56353
Phone: (320)982-7194 I Fax: (320)982-7178

2024-2025 4SR Program/Payment Options:

STUDENT INFORMATION

Student Name: _____

CLASS DESCRIPTION

We offer half-day preschool options up to five days a week. Preschool classes are 8:00 – 11:00 or 12:00 – 3:00 depending on which class you choose. We offer wrap around care if you would like your child to stay the full day. If you register your child for wrap around care, your child can be dropped off as early as 6:30 A.M. and stay as late as 6:00 P.M.

SCHOOL READINESS TUITION:

☐ We will pay the full monthly tuition amount

Prices listed are tentative rates. Rates for 24-25 have not been finalized yet.

Preschool and Wrap Around Care
5 Days = $762/Month | 3 = $478/Month | 2 = $330/Month
Preschool Only:
5 Days = $350/Month | 3 = $220/Month | 2 = $160/Month

☐ We are requesting tuition assistance (price breakdown listed below)

A copy of your most recent tax form must be provided to receive tuition assistance

Preschool and Wrap Around Care

5 Days:	$0 to $30,000 = $650/month	$30,001 - $49,999 = $688/month
3 Days:	$0 to $30,000 = $405/month	$30,001 - $49,999 = $430/month
2 Days:	$0 to $30,000 = $277/month	$30,001 - $49,999 = $294/month

Preschool Only:

5 Days:	$0 to $30,000 = $238/month	$30,001 - $49,999 = $276/month
3 Days:	$0 to $30,000 = $147/month	$30,001 - $49,999 = $172/month
2 Days:	$0 to $30,000 = $107/month	$30,001 - $49,999 = $124/month

☐ We are requesting to apply for a scholarship

**Scholarship applications will be mailed home for completion mid-July. If your child does not qualify for a scholarship, Community Ed will contact you regarding what your payment will be. Scholarships only apply towards preschool tuition. Wrap around care is a separate cost. **

PRESCHOOL CLASSES: SELECT WHICH CLASS YOU ARE REGISTERING FOR

Program Option

☐ 5 Half Days ☐ 3 Half Days ☐ 2 Half Day

Placement letters will be mailed home in May to notify you which class, days, and times your child is registered to attend.

WRAP AROUND CARE

☐ No, we will not be sending our child to wrap around care

☐ Yes, we will be sending our child to wrap around care

PARENT/LEGAL GUARDIAN OF STUDENT CERTIFICATION

Authorizing signature: _____

I understand that by registering for the School Readiness Program and/or Wrap Around Care, by signing above, I agree to fulfill my obligation by paying the monthly tuition payments on time each month. Payment is due in full by the 15th of each month. If I fail to make my monthly obligation, Milaca Public Schools will turn my account over to a collection agency by the 20th of each month to collect any monies owed to them.

OFFICE USE ONLY

Student Start Date: _____ Student End Date: _____

Program: _____ Attending Wrap Around Care: ☐ Yes ☐ No

Payment Plan: ☐ Pay in Full ☐ Requesting assistance ☐ Scholarship

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2024-2025 Payment Schedule:

Payment Info:

Placement letters will be mailed home early May to notify families which class, days, and times your child is registered to attend. Full payment info will also be included.

Before your preschooler can begin programming, you need to call Community Education at (320) 982-7307 to set up automatic payments. Monthly tuition will be automatically charged on the 15th of each month. If the 15th falls on a weekend, or holiday, Milaca Public Schools will charge your card the next business day. If the credit card on file is declined for any reason, there will be a $25.00 fee added to your monthly tuition that is due and payable immediately. It is your responsibility to make sure your credit card is up to date and the expiration date is valid. Your preschooler will not be able to attend programming until a new payment is submitted and approved.

If tuition is paid in full with cash or a check, you will receive a 10% discount for payment in full. If tuition is paid in full with a credit card you will receive a 5% discount for payment in full. Full payment must be made before the first day of preschool to qualify for the tuition discount.

Payment Schedule:

Month	Due Date
September Tuition	August 15
October Tuition	September 15
November Tuition	October 15
December Tuition	November 15
February Tuition	January 15
March Tuition	February 15
April Tuition	March 15
May Tuition	April 15

There is no tuition due for the month of January. This is a free month for all families.

Parent/Legal Guardian of Student Authorization

☐ By checking this box and signing below I, _____ understand that I am financially responsible for my child's monthly tuition obligation and agree to the above Payment Terms and authorize Milaca Public Schools to automatically charge my credit card on the 15th of each month beginning August 15, 2024 through April 15, 2025.

Authorized Signature: _____ Date: _____

Milaca Elementary School Enrollment Forms

500 Highway 23 West, Milaca, MN 56353
Phone: (320)982-7301 | Fax: (320)982-7178

STUDENT INFORMATION

Name (Legal): _____ _____ _____
(Last) (First) (Middle)

Birth Date: _____ / _____ / _____ Gender: □ Female □ Male Grade Enrolling: _____
Month Day Year

Name child is to be called in school: _____

RESIDENCY INFORMATION:

Physical Home Address for child: _____
Street and/or PO Box City, State Zip Code

Mailing Address (if different than physical): _____
Street and/or PO Box City, State Zip Code

Is physical address located in the Milaca School District: □ Yes □ No (please request Open Enrollment Form)

Who does the child live with? □ Both Father and Mother □Father and Stepmother □Mother and Stepfather
□ Father Only □Mother Only □Foster Parent(s)
□ Other: _____

BIOLOGICAL FATHER INFORMATION:

Father _____ Employer: _____

Address: _____ City/State/Zip _____
If different than student's address

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email _____ Contact allowed? □ Yes □ No

BIOLOGICAL MOTHER INFORMATION:

Mother _____ Employer: _____

Address: _____ City/State/Zip _____
If different than student's address

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email _____ Contact allowed? □ Yes □ No

OTHER ADULT #1 INFORMATION (If student lives with):

Full Name: _____ Relation to Student: _____

Address: _____ City/State/Zip _____

Home: _____ Work: _____ Cell: _____ Employer: _____

Email _____ Contact allowed? □ Yes □ No

OTHER ADULT #2 INFORMATION (If student lives with):

Full Name: _____ Relation to Student: _____

Address: _____ City/State/Zip _____

Home: _____ Work: _____ Cell: _____ Employer: _____

Email _____ Contact allowed? □ Yes □ No

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ETHNIC AND RACIAL DEMOGRAPHIC

☐Yes ☐No 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

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 ☐ Colombian ☐ Ecuadorian ☐ Guatemalan ☐ Mexican
☐ Puerto Rican ☐ Salvadoran ☐ Other Hispanic/Latino ☐ Unknown
☐ Spaniard/Spanish/Spanish-American

☐Yes ☐No 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*

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 ☐ Cherokee ☐ Anishinaabe/Ojibwe
☐ Dakota/Lakota ☐ Other North American Indian Tribal Affiliation ☐ Unknown

☐Yes ☐No Is the student American Indian from South or Central America?

☐Yes ☐No 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.

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 ☐ Asian Indian ☐ Burmese ☐ Chinese ☐ Filipino
☐ Hmong ☐ Karen ☐ Korean ☐ Vietnamese ☐ Other Asian
☐ Unknown

☐Yes ☐No 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.

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 ☐ African-American ☐ Somali ☐ Ethiopian-Oromo ☐ Liberian
☐ Ethiopian-Other ☐ Nigerian ☐ Other black ☐ Unknown

☐Yes ☐No 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.

☐Yes ☐No 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

HOME LANGUAGE INFO:

	Check the phrase that best describes your student:	Indicate language(s) other than English
My student first learned:	☐only English ☐ language(s) other than English ☐ English and other language(s)	
My student speaks:	☐only English ☐ language(s) other than English ☐ English and other language(s)	
My student understands:	☐only English ☐ language(s) other than English ☐ English and other language(s)	
My student has consistent interaction in:	☐only English ☐ language(s) other than English ☐ English and other language(s)	

PARENT/LEGAL GUARDIAN OF STUDENT CERTIFICATION

Printed Name: _____ Signature: _____ Date: _____

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Student Services/Additional Info:

OTHER SIBLINGS OF THE STUDENT INFORMATION:

Last Name:	First Name:	Middle Name:	Gender:	DOB
_____	_____	_____	☐M ☐F	____/____/____
_____	_____	_____	☐M ☐F	____/____/____
_____	_____	_____	☐M ☐F	____/____/____
_____	_____	_____	☐M ☐F	____/____/____

STUDENT'S PERSONAL INFORMATION / MILITARY-CONNECTED YOUTH:

☐Yes ☐No Has student ever registered under a different name? If YES, what name: _____

☐Yes ☐No Is the Student a Ward of the County or State? If YES, what county: _____

☐Yes ☐No Does this student have an immediate family member, including a parent or sibling, who is currently in the armed forces either as a reservist or on active duty or has recently retired from the armed forces?

☐Yes ☐No If yes, is the family member on active duty?

☐Yes ☐No In the past 3 years have you or anyone in your family moved (city, state or school district) so that you or a family member could work or look for /seasonal or temporary, agricultural or fishing work?

FOSTER CARE INFORMATION (ONLY COMPLETE IF STUDENT IS IN FOSTER CARE)

Which type of foster care placement is the student living with? ☐Relative Caregiver ☐Non-Relative Caregiver

Has parent's rights been terminated? ☐Yes ☐No

EMERGENCY CONTACT INFO

People other than the student's parent /legal guardian the school can call if the school cannot reach the parent/legal guardian

Full Name: _____ Relation to Student: _____

Home: _____ Work: _____ Cell: _____

Full Name: _____ Relation to Student: _____

Home: _____ Work: _____ Cell: _____

Full Name: _____ Relation to Student: _____

Home: _____ Work: _____ Cell: _____

4SR BUS TRANSPORTATION REQUEST

Only fill out if your child will be riding the bus – busing is only available in the morning to school and in the afternoon going home from school – we do not offer mid-day transportation

4 year old School Readiness students may ride the Milaca School bus. Children will be encouraged to sit in the first five seats of the bus. Children should have a buddy to sit next to on the bus each time. The buddy can be a sibling, neighbor, relative, or friend.

STUDENT INFORMATION

Student Name: _____DOB _____ Home Phone: _____

Student Address: _____
(Street #, Street Name, apt #) (City) (Zip)

Parent/Guardian Name: _____ Daytime Phone: _____

Parent/Guardian Name: _____ Daytime Phone: _____

TRANSPORTATION DETAILS:

To School (before 8:00 A.M.)

☐ Bus pick up

☐ Child will walk/Parent/Guardian transport

From School (after 3:00 P.M.)

☐ Bus drop off

☐ Child will walk/Parent/Guardian transport

PICK UP/DROP OFF LOCATION INFORMATION:

Home, Daycare or Contact Name: _____

Daycare or Contact Address: _____

Daycare or Contact Phone Number: _____ Alternative # _____

SIBILINGS AND/OR BUDDY RIDING WITH CHILD ON BUS:

Sibling Name: _____ Grade: _____

Sibling Name: _____ Grade: _____

Buddy (sitting with child on bus): _____

TRANSPORTATION DISCLAIMER:

Each child will be given a two week bus trial period. If for some reason the bus does not work for the parents or the bus company within the two week trial, the child will no longer use the bus.

North Central Transportation Phone: (320)982-2294 | Fax: (320)982-5854
Sue's Bus Service - Phone: (320)556-3482 | Fax: (320)556-3691

GENERAL INFORMATION: This questionnaire should be completed only ONE TIME per school year FOR EACH FAMILY ENROLLED in the Early Childhood Family Education (ECFE) and/or the School Readiness Program. Each family is asked to voluntarily provide participant information that will be used for local and state program planning and evaluation. If you do not provide this information, it will not prevent you or your child from participating in ECFE or School Readiness. Only one family member should complete this questionnaire. DO NOT write your name on this form. The information that you provide will be kept confidential and WILL NOT be directly connected with you or your family.

Minnesota Department of Education

SCHOOL YEAR

1. Please indicate whether you are this child's
   - ☐ Mother ☐ Father ☐ Grandmother ☐ Grandfather
   - ☐ Foster Mother ☐ Foster Father ☐ Guardian ☐ Other Relative

2. Your highest level of school completed (mark only one box):
   - ☐ Eighth Grade ☐ Associate's Degree
   - ☐ 12th Grade ☐ Bachelor's Degree
   - ☐ High School Diploma ☐ Master's Degree
   - ☐ Some college but no degree ☐ PH. D.

3. Your Date of Birth (Month/Day/Year): ____ | _____ | _____

4. Your current job status (mark only one box):
   - ☐ Employed more than 25 hours per week ☐ Unemployed, seeking employment
   - ☐ Employed less than 25 hours per week ☐ Unemployed, not seeking employment

5. The racial/ethnic of your children (check all that apply)
   - ☐ White ☐ Black/African American ☐ Hispanic or Latino ☐ Asian
   - ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian/Alaskan Native
   - ☐ Other, single race ☐ Other, two or more races

6. What are your primary languages (circle all that apply)
   - ☐ English ☐ Arabic ☐ Spanish ☐ Russian
   - ☐ Hmong ☐ Mandarin ☐ Somali ☐ Laotian
   - ☐ Vietnamese ☐ Oromo ☐ Karen ☐ Cambodian
   - ☐ Other: _____

7. What was your household's total yearly income, before taxes last year, rounding to the nearest thousand?
   $ _____

8. How many people were in your household last year?
   ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

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Student Health Update Form

A copy of your child's immunization record must be turned in before your child can start

STUDENT INFORMATION

Name (Legal): _____ _____ _____
(Last) (First) (Middle)

DOB: _____ I _____ I _____ Primary Doctor: _____ Clinic: _____

HEALTH HISTORY INFORMATION

This information is required in order to provide appropriate health services for your student. This data will be treated as private data and will be recorded in the Student Health Record.

Has your child ever had or has now? (Please check all that apply):

- ☐ Allergies (Food, Medications, etc.)
- ☐ Needs an Epi-pen
- ☐ Acid Reflux
- ☐ ADD/ADHD
- ☐ Asthma
- ☐ Cancer
- ☐ Concussion
- ☐ Corrective Lenses (Contacts/Glasses)
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Eye Problems
- ☐ Hearing Aid
- ☐ Hearing Loss
- ☐ Heart Condition
- ☐ Hepatitis
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Problems
- ☐ Mental Disability
- ☐ Migraines
- ☐ Physical Disability
- ☐ Sickle Cell Disease
- ☐ Speech Problems
- ☐ Tuberculosis
- ☐ Vision Loss

Has your child had the Chicken Pox? ◯ Yes ◯ No If YES, what month and year: _____ /_____

Has your child been hospitalized for illness, surgery, or injury? ◯ Yes ◯ No

Year: _____ Reason: _____

Does your child take any medication? ◯ Yes ◯ No

If yes, please explain: _____

_____

Please list any severe allergies: _____

Is your child under regular medical supervision for any of the above conditions? ◯ Yes ◯ No

If emergency treatment is required and you can't be reached immediately, may the school authorities use their judgment in calling an ambulance? ◯ Yes ◯ No

I give permission for the school nurse to communicate to the student's teachers and other school employees who may provide services for my child, about the student's health condition(s) via the school's "Confidential Health Report", and the action of any medication the student may be taking on an "as need to know basis." ☐ Yes ☐ No

Parent/Guardian Signature: _____ Date: _____

Permission Sign-off Form

This form is a comprehensive tool that provides Milaca School District parents/guardians the opportunity to give permission for several items of importance at one time. This permission will remain in effect throughout your child's school career. If your permission preferences change, you may submit a new form.

Student Name: _____

Parent/Guardian Name:_____ Signature: _____ Date: _____

CIRCLE BELOW

Please read the following statements and circle "yes" or "no" for each item that you are providing permission for your student to participate. In addition, please discuss and complete the "Student Internet Acceptable Use and Safety Agreement" form with your student.

INTERNET USE AGREEMENT: ◯YES ◯NO

I give permission for my child to use the Internet, computers, iPad and equipment provided by Milaca School District. I understand and accept the responsibilities and liabilities that are placed on me and my child as a result of signing this contract should my child violate the rules as stated in the Internet Safety Agreement Policy. I understand that the Internet contains some material that is inappropriate for minors. I support the School District's position that students are individually responsible for not accessing such material. Unacceptable use of the School District's Internet access will result in possible suspension of privileges or other discipline. I will not hold the District liable for any inappropriate information my child may encounter or any unwanted financial obligations that may result by using the School District's Internet access.

DISPLAYING SCHOOL WORK: ◯YES ◯NO

I give permission for my child's course work or art projects to be displayed in school district buildings, on school and district Web pages, and in school and district publications and videos. Student work may or may not be accompanied by the students' name.

DISPLAYING/PUBLISHING PHOTOGRAPHS/DIGITAL IMAGES/VIDEOS: ◯YES ◯NO

I give permission for my child's picture/digital image or video to be taken either individually or in a group setting to be displayed in school district buildings, community locations, in local newspapers, on school and district Web pages (including district YouTube and Facebook page), videos or other electronic media, or other public publications/electronic media.

WALKING FIELD TRIPS: ◯YES ◯NO

I give permission for my child to take walking field trips off school grounds during the school year.

SCHOOL ALERTS: ◯YES ◯NO

I give permission to receive alerts regarding school information.

SCHOOL COMMUNICATION: ◯EMAIL ◯PAPER

In an effort to support the Go Green Initiative, we are asking all parents who have email access to provide the school with email addresses to keep you updated on the school's current events.

Enter the dates for each vaccine your child has received to date. Specify the month, day, and year of each dose such as 01/01/2010.

Immunization Form

Name_____ Birthdate_____

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

Vaccine	Birth to 6 months			12 -24 months		At Kindergarten	At 7th grade	At 12th grade
Hepatitis B								
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)								
Haemophilus influenzae type b (Hib)								
Pneumococcal (PCV)								
Polio								
Measles, Mumps, Rubella (MMR)								
Chickenpox (varicella)								
Hepatitis A								
Tetanus, Diphtheria, Pertussis (Tdap)								
Meningococcal (MCV4)								

Complete this form or bring a copy of your child's immunization record

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:

1. 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.
2. 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.

DEPARTMENT OF HEALTH
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		
Haemophilus influenzae type b		
Chickenpox (varicella)		
Pneumococcal		
Hepatitis A		
Hepatitis B		
Meningococcal		

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*)

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 Signature: _____

Notary Stamp

STATE OF MINNESOTA, COUNTY OF _____

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.

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:

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