2022-2023 Toddler & Preschool

Enrollment Application and Packet

5140 Fremont Ave N, Minneapolis, MN 55430

Ph. 612-302-3410

Fax 612-302-5911

office@jjlegacy.org

www.jjlegacy.org

https://www.facebook.com/OFFICIALJJLegacy/

https://twitter.com/JJlegacyschool

https://www.linkedin.com/company/jjlegacyschool/

https://www.instagram.com/JJlegacyschool/

2022-2023 Application for Enrollment | *Toddler & Preschool*

Enrolling Application: 16 months - 5 years old, after Sept. 1, 2022

Legacy of Dr. Josie R. Johnson Montessori Preschool will accept applications for enrollment for the 2022-2023 academic year. If you wish to enroll your child at Legacy of Dr. Josie R. Johnson Montessori Preschool, please complete the application below and submit it by mail, in person, or by fax (*see the contact information at the bottom of this page*). After March 20, 2022, applications will be accepted on a rolling basis if space is available.

Student Information (*please print clearly*)

Last Name: _____ First Name: _____

Street Address: _____ City / State / Zip: _____

Birth Date: _____/ _____/ _____

(If you would like to enroll your child in Kindergarten, please fill out the K-6 Application; your child must be age 5 by 09/01/2022.)

Do you have other students already attending Legacy of Dr. Josie R. Johnson Montessori? **YES | NO**

Parent / Guardian Information (*please print clearly*)

Parent / Guardian 1 _____

E-mail Address _____ Phone _____

Parent / Guardian 2 _____

E-mail Address _____ Phone _____

Desired Start Date *(please circle one)* *Now* *Future* *In the future, when?*_____

The Minnesota Government Data Practices Act requires that you be informed that the information you provide is considered private. You are not legally required to provide any information on this enrollment application. Legacy of Dr. Josie R. Johnson Montessori School staff will have access to any information you provide and use it in the enrollment process. Failure to provide the information requested would necessitate that an enrollment decision be made without the benefit of reviewing the information you could provide. If you do provide the requested information, it is our expectation that any information you provide will be truthful.

I hereby verify that the above information is true and correct to the best of my knowledge.

Signature of Parent/Guardian _____ Date _____

No child will be denied admission to Legacy of Dr. Josie R. Johnson Montessori School on the basis of gender, religion, ethnicity, immigrant (legal or non) status, or intellectual or physical ability. Students from all backgrounds are encouraged to apply.

04/01/2022 (LJJM Office Use) Date Received:_____ Notice of Enrollment Sent on Date:_____

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2022-2023 Enrollment Form | *Toddler & Preschool*

Please Note: The $60.00 Registration Fee (non-refundable) is due at this time..

Toddler Community (16 to 36 months):	
__5 days/week *(Mon-Fri)* (OR) __4 days/week (Mon-Thu)	
___ Half Day with Lunch	9:00am - 12:45pm*
___ Full Day	9:00am - 4:00pm*

*Schedules subject to change.

Preschool (3 to 5 years):	
__5 days/week *(Mon-Fri)* (OR) __4 days/week (Mon-Thu)**	
___ Half Day with Lunch	9:00am - 12:45pm*
___ Full Day	9:00am - 4:00pm*

*Schedules subject to change **4 days/week is a Full day option only

Today's Date **Student's Full Name (First Middle Last)**

Home Address **City** **State** **ZIP** **Home Phone** ( )

Birth Date **Birth Place** **Gender** **Current Age** **Desired Start Date**
___Now ___Spring ___Summer ___Fall ___Winter

Through what age do you anticipate your child attending Legacy of Dr. Josie R. Johnson?

Have you applied to Legacy of Dr. Josie R. Johnson before?

Name of previous School/Daycare: **Dates Attended:**

Previous School/Daycare Owner/Director Name: __/__/___ — __/__/___

Previous School/ Daycare Address:

Previous School/ Daycare Phone number:

Please provide 2 references from non-family members :

1) **Name:**_____ **Phone number:** _____
2) **Name:**_____ **Phone number:** _____

Parent/Guardian 1 (Full Name) **Email Address**

Address (if different than above) **City** **State** **ZIP** **Cell Phone** ( )

Occupation **Employer** **Employer City** **Work Phone** ( )

Parent/Guardian 2 (Full Name) **Email Address**

Address (if different than above) **City** **State** **ZIP** **Cell Phone** ( )

Occupation **Employer** **Employer City** **Work Phone** ( )

Office use only: Date received: __-__-____ Reg. Fee received: Initial_____

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2022-2023 Enrollment Form | *Toddler & Preschool*

STUDENT INFORMATION

Child's Name*_____
Last Name First Name Middle Name

**Please enter the student's full legal name as it appears on their birth certificate*

Name student goes by (if different from legal name above):_____

Male____ Female____ Date of Birth:_____ Age:_____ Place of Birth_____

Has the student or student's sibling attended JJ Legacy in the past? (*please circle one*) Yes No

If yes, sibling's name: _____

Is a sibling of this student applying for enrollment for the 2022-2023 school year? (*please circle one*) Yes No

If yes, sibling's name _____

PRIMARY HOUSEHOLD INFORMATION

List only parent/guardians who reside at this address

Student's Primary Street Address: _____ City: _____ Zip Code_____

Primary Parent/Guardian Name #1_____

Relationship to student:_____

Phone: (H) _____(C*) _____(W) _____

E-mail* _____

Primary Parent/Guardian Name #2_____

Relationship to student:_____

Phone: (H) _____(C*) _____(W) _____

E-mail*: _____

What is the preferred method of communication with Legacy of Dr. Josie R. Johnson?

___Phone ___ Email ___Text

Student lives at this address (*please circle one*) Full Time Part Time

**All cell phone numbers provided will be added to our emergency notification system. E-mails will be added to our email distribution list.*

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Student's Name_____

SECONDARY HOUSEHOLD INFORMATION *(if applicable)*

List only parent/guardians who reside at this address

Street Address: _____ City: _____ Zip Code:_____

Parent/Guardian Name #1_____

Relationship to student:_____

Phone: (H) _____(C) _____(W) _____

E-mail: _____

Parent/Guardian Name #2_____

Relationship to student:_____

Phone: (H) _____(C) _____(W) _____

E-mail: _____

Does your child live at this address? (*please circle one*) Yes No If yes, how often? *(please circle one)*

Full Time Part Time

NON-HOUSEHOLD EMERGENCY CONTACTS

	Name of Contact/ Relationship to Child	Phone Number	Driver's License #	Authorized to Pick up?
1		❑ Home ❑ Cell ❑ Work		Yes / No
2		❑ Home ❑ Cell ❑ Work		Yes / No
3		❑ Home ❑ Cell ❑ Work		Yes / No

Parental Permission: By listing the contacts above, you give Legacy of Dr. Josie R. Johnson Montessori School staff permission to call these contacts when there is an emergency and you are not able to be reached. Legacy of Dr. Josie R. Johnson Montessori School staff will also use these contacts as a reference when someone other than yourself may need to pick up your child from school. All contacts must show identification before the student will be released. Any person not listed on this form may not pick up your child from school. If you need to change this information, please stop by the office at any time to obtain a new form.

Parent Signature:_____ Date:_____

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NON-HOUSEHOLD EMERGENCY CONTACTS - Extended List (if applicable)

	Name of Contact/ Relationship to Student	Phone Number	Driver's License #	Authorized to Pick up?
1		❑ Home ❑ Cell ❑ Work		Yes / No
2		❑ Home ❑ Cell ❑ Work		Yes / No
3		❑ Home ❑ Cell ❑ Work		Yes / No
4		❑ Home ❑ Cell ❑ Work		Yes / No
5		❑ Home ❑ Cell ❑ Work		Yes / No
6		❑ Home ❑ Cell ❑ Work		Yes / No
7		❑ Home ❑ Cell ❑ Work		Yes / No
8		❑ Home ❑ Cell ❑ Work		Yes / No
9		❑ Home ❑ Cell ❑ Work		Yes / No
10		❑ Home ❑ Cell ❑ Work		Yes / No

Parental Permission: By listing the contacts above, you give Legacy of Dr. Josie R. Johnson Montessori School staff permission to call these contacts when there is an emergency and you are not able to be reached. Legacy of Dr. Josie R. Johnson Montessori School staff will also use these contacts as a reference when someone other than yourself may need to pick up your child from school. All contacts must show identification before the student will be released. Any person not listed on this form may not pick up your child from school. If you need to change this information, please stop by the office at any time to obtain a new form.

Parent/Guardian Signature:_____**Date:**_____

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Special Services Form

Child's Name: _____
Last Name First Name Middle Name

1. Does this student currently receive specialized services on an Individual Education Plan (IEP)? Yes | No

a. If yes, through which school district? _____

b. If yes, please identify the areas of service or primary disability area from the options below:

Autism Spectrum Disorder | Visually Impaired | Deaf - Hard of Hearing | Deaf – Blind |
Developmental Cognitive Disabilities Mild-Moderate | Developmental Cognitive Disabilities Severe-Profound |
Developmental Delay | Emotional or Behavioral Disorders (EBD) | Other Health Disabilities |
Physically Impaired | Severely Multiply Impaired | Specific Learning Disabilities |
Speech or Language Impaired | Traumatic Brain Injury Disabled / or Uncertain
Other: _____

**Please attach a copy of the IEP and recent evaluations to this registration*

2. Does this student currently receive accommodations through a 504 plan? Yes | No
**Please attach a copy of the 504 plan to this registration*

3. Does your student currently receive English as a Second Language (ELL) services? Yes | No

4. Does this student currently receive Gifted and Talented services? Yes | No

5. Is the student Homeless? Yes | No
A student may be homeless if:
☐Shared housing (doubled up) due to loss of housing, economic hardship, or similar reason
☐Living in cars, parks, public spaces, abandoned building, not a regular sleeping place
☐Hotels or motels
☐ Emergency/transitional shelters; awaiting foster care

6. Is the student in Foster Care? Yes | No

APPLICATION SIGNATURE
I certify the information given above is true and complete to the best of my knowledge.

Enrolling Parent/Guardian Name: _____ **Phone Number:** _____
(please PRINT name)

Enrolling Parent/Guardian Signature: _____ **Date:** _____
(please SIGN name)

***Please note: Legacy of Dr. Josie R. Johnson partners with districts for our Pre-K Special Education services.**
*******A BIRTH CERTIFICATE AND IMMUNIZATION RECORD IS REQUIRED FOR ALL STUDENTS ENROLLING*******
In accordance with federal law and U. S. Department of Education policy, this institution does not discriminate on the basis of race, color, national origin, sex, age, or disability.

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Health and Wellness Form

Student's Name:

_____

First **Middle** **Last**

Birth Date _____/_____/_____ **Gender** _____

HEALTH CONCERNS: Please check if your child has any of the following health concerns.

____ NO HEALTH CONCERNS

____ A.D.H.D./A.D.D.

____ Allergies (to what?)_____

____ Asthma or other respiratory problems (describe)_____

____ Bladder problems/bowel problems (describe) _____

____ Heart problems (describe) _____

____ Seizures (describe)_____

____ Social/emotional/mental health (describe) _____

____ Hearing problems (describe) _____

____ Vision problems (describe) _____

Do you have any concerns about your child's development? *(please circle one)* **Yes** **No** If yes, please comment:

_____

_____

Please describe any special developmental needs your child has that we should be aware of:

Speech/Language:_____

Motor development:_____

Self-help skills:_____

Attention spans:_____

Emotional needs:_____

Social development:_____

Behavioral problems:_____

Does your child have any known health problems that could result in an emergency? *(please circle one)* **Yes** **No**
If yes, please explain and attach documentation

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Check (X) any of the following illnesses the child has had:

( ) Asthma ( ) Earaches ( ) Mumps ( ) Whooping Cough ( ) Bronchitis ( ) Convulsions
( ) Pneumonia ( ) Polio ( ) Chicken Pox ( ) Frequent Colds ( ) Eczema ( ) Rheumatic Fever
( ) Measles ( ) Influenza ( ) Diphtheria ( ) Tonsillitis ( ) Croup
( ) Other _____

Has your child had any surgery? *(please circle one)* **Yes No** If yes, please explain:

_____

_____

MEDICATIONS: List **ALL** medications that your child takes daily or when needed. A consent form is **REQUIRED** for **ALL** medication taken at school, including over the counter medications. **THE CONSENT MUST BE SIGNED BY BOTH HEALTH CARE PROVIDER AND PARENT.** A new consent is needed each school year. Forms are available in the health office.

Medication Name	Purpose	Dose	How often taken?

HEALTH INSURANCE: My child has health insurance: *(please circle one)* **Yes No**

Medical Ins. Co:_____ Policy Number:_____Exp.Date:_____

Medical Assistance Number:_____

HEALTH CARE PROVIDERS:
Does your child have a doctor or clinic where they usually go for health care? *(please circle one)* **Yes No**
Does your child have a dentist or clinic where they usually go for dental care? *(please circle one)* **Yes No**

Doctor Name:_____ Clinic Name:_____Phone:_____

Dentist Name:_____Clinic Name:_____Phone:_____

Hospital preference in case of emergency: _____

❑ I authorize staff to obtain the following services for this child if necessary: Public Health Nurse, Physician and or Ambulance in the event of an emergency. (Ambulance fees and/or health care costs are the responsibility of the parent/guardian)

Parent/Guardian Printed Name: _____ **Phone Number:** ____-_____-_____

Parent/Guardian Signature:_____ **Date:**_____/_____/_____

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Race/Ethnicity Form

Child's Name: _____
Last Name First Name Middle Name

Birth Date: _____/_____/_____ Country of Birth: _____

PLEASE COMPLETE SECTIONS A., B., & C.

A. For State Reporting purposes, please check the ONE response that best describes your child.

☐ **American Indian or Alaska Native** (persons having origins in any of the original peoples of North America and maintain cultural identification through tribal affiliation or community recognition.)

☐ **Asian or Pacific Islander** (persons having origins in any of the original peoples of the Far East, Southeast Asian, the Pacific Islands or the Indian subcontinent. This area includes China, India, Japan, Korea, Philippine Islands, and Samoa.)

☐ **Hispanic** (persons of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin- regardless of race.)

☐ **Black, not of Hispanic origin** (persons having origins in any of the Black racial groups of Africa.)
White, not of Hispanic origin (persons having origins in any of the original peoples of Europe, North Africa or the Middle East.)

☐ **White, not of Hispanic origin** (persons having origins in any of the original peoples of Europe, North Africa or the Middle East.)

B. For federal reporting purposes, check ONE answer that describes your child's Hispanic Ethnicity.

☐ **Yes** (Mexican, Puerto Rican, South or Central Americans and other Spanish culture or origin, regardless of race.)

☐ **No** (Not Hispanic or Latino)

C. For federal reporting purposes, check ALL that apply to your child:

☐ **American Indian or Alaska Native** (persons having origins in any of the original peoples of North America or South America, including Central America and maintains a tribal affiliation or community attachment.)

☐ **Asian** (persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian sub-continent. Including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippine Islands, Thailand and Vietnam.)

☐ **Black, not of Hispanic origin** (persons having origins in any of the black racial groups of Africa.)
Native Hawaiian or other Pacific Islander (a person having origins in any of the original people of Hawaii, Guam, Samoa, or other Pacific Islands.)

☐ **Native Hawaiian or other Pacific Islander** (a person having origins in any of the original people of Hawaii, Guam, Samoa, or other Pacific Islands.)

☐ **White** (a person having origins in any of the original peoples of Europe, North Africa, or Middle East.)

Parent/Guardian Signature_____ Date:_____

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SY22-23 Photos and Field Trip Permission Form

Child's Name: _____
Last Name First Name Middle Name

Photographs and Videos

Permission for Photographs and Video to be taken during school events, field trips, or in the classroom. The intention of the photos/videos would not be for marketing or for social media.

- ☐ Yes - I authorize Legacy of Dr. Josie R. Johnson Montessori to take photos or videos of my child
- ☐ No - I do NOT authorize Legacy of Dr. Josie R. Johnson Montessori to take photos or videos of my child

Photo and Video Media Release

Legacy of Dr. Josie R. Johnson Montessori Montessori School maintains a website on the internet and uses pictures and videos of students participating in classroom activities, field trips and special school events. We also use photos and video of students in the yearbook and if Legacy of Dr. Josie R. Johnson Montessori Montessori School is featured in the press.

I hereby irrevocably grant Legacy of Dr. Josie R. Johnson Montessori Montessori School the absolute right and permission to copyright and/or us photographs, and/or portraits of my family and myself or in which we may be included in whole or part, or composite, distorted in character or form, in conjunction with our name or a fictitious name or reproduction thereof, in a color or otherwise, made through media, for art, advertising or any other lawful purpose whatsoever. I also grant Legacy of Dr. Josie R. Johnson Montessori Montessori School the same right and permission to use any statements or testimonials made by my family or myself.

- ☐ Yes - My child's photograph/video/interview may be used for media
- ☐ No - My child's photograph/video/interview may NOT be used for media

Permission for Walking Field Trips

Occasionally classrooms choose to explore nature or travel by foot in the school community.

- ☐ Yes - I give permission for my child to participate in walking field trips outside the school and within the Legacy of Dr. Josie R. Johnson Montessori Montessori School community.
- ☐ No - I do NOT give permission for my child to participate in walking field trips outside the school and within the Legacy of Dr. Josie R. Johnson Montessori Montessori School community.

Permission for Riding Field Trips

When going on a field trip we will be using a school bus. There will be separate notification and permission forms for each field trip that will give you information on the specifics of the trip.

- ☐ Yes - I give permission for my child to participate in riding field trips by bus or van.
- ☐ No - I do NOT give permission for my child to participate in riding field trips by bus or van.

Parent/Guardian Name: _____ **Child's Classroom:** _____
(please PRINT name)

Parent/Guardian Signature: _____ **Date:** _____
(please SIGN name)

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Parent Questionnaire (Complete one per family)

Yes | **No** I am new to Legacy of Dr. Josie R. Johnson Montessori Montessori School.

Yes | **No** My child or his/her siblings have attended Legacy of Dr. Josie R. Johnson Montessori Montessori School in the past.

Yes | **No** My child has siblings who currently attend Legacy of Dr. Josie R. Johnson Montessori Montessori School.

If Yes, list siblings who attend Legacy of Dr. Josie R. Johnson Montessori :

_____

_____

_____

_____

If you are new, how did you hear about us?

_____ From a past or present Legacy of Dr. Josie R. Johnson Montessori Family. Who?: _____

_____ Flyer or postcard. Where did you get it?: _____

_____ Drove by school

_____ School sign

_____ Lawn Sign

_____ Website

_____ Facebook page

_____ Internet search

_____ A community event. Which event?: _____

_____ Word of Mouth. Person(s) referring you:_____

_____ Other, please specify: _____

Does any parent / guardian of this student have special talents or resources to offer our school or teachers?

_____

_____

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Minnesota Language Survey

Child's Name: _____
Last Name First Name Middle Name

Birth Date: _____/_____/_____ **Classroom:** _____

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.

Questions for Parents or Guardians	Check the phrase that best describes your student:	Indicate the language(s) other than English in the space provided:
1. My student first learned:	___ language(s) other than English. ___ English and language(s) other than English. ___ only English.	
2. My student speaks:	___ language(s) other than English. ___ English and language(s) other than English. ___ only English.	
3. My student understands:	___ language(s) other than English. ___ English and language(s) other than English. ___ only English.	
4. My student has consistent interaction in:	___ language(s) other than English. ___ English and language(s) other than English. ___ 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 Name: _____ **Child's Classroom:** _____
(please PRINT name)

Parent/Guardian Signature: _____ **Date:** _____
(please SIGN name)

* 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.

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2022-2023 My Child's Story | *Toddler & Preschool*

Today's Date: _____

Child's Name: _____ **Date of Birth:** _____

Child's Nickname: _____

Your Name: _____ **Relationship:** _____

The following information will enable us to get to know your child better. Thank you for your thoughtful responses!

List the family members the child lives with (adults and children):

Name	Relationship to student	Age (if a child)

What culture do you consider most important to your child's identity?

_____

What language(s) is/are spoken in your child's home(s)?

_____

What are your child's background, interests, strengths and abilities?

_____

_____

_____

What are your family routines?

_____

_____

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2022-2023 My Child's Story | *Toddler & Preschool*

Please describe your child's social interactions and emotional development (playdates/groups, etc).

Does your child have any fears? If so, please describe.

Does your child display any challenging behaviors that are difficult to manage?

Has your child experienced any major changes in their family lifestyle or living arrangements, such as the death of a relative, divorce, or a move to a new residence? Please describe.

Is this your child's first time being in a school setting? Do you have any concerns? If so, please describe.

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Is there any significant dietary or medical history regarding your child that we should be aware of?

If there has been any previous evaluations or educational testing, please provide Legacy of Dr. Josie R. Johnson Montessori School a copy of the documents.

On average, how much "screen time" (television, computers, phones, tablets) does your child view daily/weekly?

What are your educational goals for your child? How do you see JJ Legacy partnering with your family to assist with these goals?

As partners in supporting the education of your child, we expect parents to attend several parent education events a year. In addition, what role can we expect you, as the child's parents and guardians, to play in facilitating your child's educational goals?

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2022-2023 My Child's Story | *Toddler & Preschool*

Please provide a brief description of your child's eating habits, sleeping patterns and communication style. Please also tell us anything else you would like us to know about your child.

_____

_____

_____

_____

For Parents of Toddlers only:
Is your child using diapers/pull-ups? If not, does your child have toileting accidents? How often? When are they most likely to occur?

_____

_____

To facilitate your child's transition to a Montessori environment, please encourage your child to do the following independently:

- **dressing**
- **undressing**
- **eating**
- **Toileting (to be eligible for Pre-K, the child must be fully potty trained - successful up to 2 months minimum)**
- **and other practical life skills**

Thank you for allowing us the opportunity to get to know your child better!

Please return your My Child's Story to the Front office:

office@jjlegacy.org

P: 612-302-3410

F: 612-3025911

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Health Care Summary For Child Care Attendance

(to be completed by physician/nurse practitioner)

Program Name: _____ Date of enrollment: ___/___/___
Child's Name: _____ Date of Birth: ___/___/___
Address: _____
Street City State Zip Phone No.
Parent/Guardian: _____

Date of last physical exam: _____

Is the child up-to-date on their immunizations? ☐ Yes ☐ No

If no, plan for bringing the child up-to-date _____

Copy of immunizations attached and signed by health care provider? ☐ Yes ☐ No

Allergies: _____

Does the child have any important health concerns that you are following them for? _____

Does the child have any important health concerns that are followed by another source of health care? (if so, please give name of provider and condition requiring attention) _____

Does the child have any special needs that require accommodation by the provider? _____

Does the child have any conditions that may result in an emergency? _____

Does the child have any activity restrictions? _____

Is a modified diet necessary? _____

Does the child require a different sleep position other than on their back? _____

What is the status of the child's Vision: _____

Hearing: _____ Speech: _____

Is there any other information that would be helpful in a group care setting? _____

Primary health care providers name: _____

Clinic Name: _____ Phone #: ( ) _____

Address: _____
Street City State Zip

Signature of Health Care Provider: _____ Date _____

Individual Child Care Program Plan
Child with Severe Allergies/ Allergies

FORM A-500
©Revised 3/18

Place Child's Picture Here

Child's Name: _____ Date of Birth: ___/___/___

Allergy to: _____

_____

Any other known triggers: _____

Signs of an allergic reaction include: (*May differ from each exposure and severity of symptoms can quickly change.*)

Systems:	Symptoms:
• Mouth	itching and swelling of the lips, tongue, or mouth
• Throat*	itching and/or a sense of tightness in the throat, hoarseness and hacking cough
• Skin	hives, itchy rash, and/or swelling about the face or extremities
• Gut	nausea, abdominal cramps, vomiting, and/or diarrhea
• Lung*	shortness of breath, repetitive coughing, and/or wheezing
• Heart*	"weak" pulse, "passing-out"

*** All above symptoms can potentially progress to a life-threatening situation!**

TO BE COMPLETED BY HEALTH CARE PROVIDER

If reaction is suspected give IMMEDIATELY:

Treatment prescription #1: _____ Dosage: _____

For the described symptoms: _____

Treatment prescription #2: _____ Dosage: _____

For the described symptoms: _____

Precautions and/or possible adverse reactions: _____

Contact emergency medical services whenever epinephrine is used.

(A single dose of epinephrine wears off in 15-20 minutes)

Other pertinent information: _____

Please note: In the case of a severe allergy to bee stings, the provider will attempt to quickly remove the stinger by scraping with a fingernail or other object.

Physician's signature: _____ Date: ___/___/___

EMERGENCY PHONE NUMBERS

Parent/Guardian #1: _____

Name Home # Work # Other #

Parent/Guardian #2: _____

Name Home # Work # Other #

(See emergency contact information for alternate if parents are unavailable)

Primary health care provider's name: _____ emergency phone: _____

Specialist's name (if any): _____ emergency phone: _____

I give my permission for the provider to follow this plan of care prescribed by the physician. I also give my permission to call the health care provider(s) listed above for any additional medical information about my child. I understand that a photo of my child including my child's name and specific allergies and treatment will be posted at the program.

Parent/Guardian's signature: _____ Date: ___/___/___

- Over -

TO BE COMPLETED BY CHILD CARE PROVIDER

Techniques to avoid exposure: _____

_____

_____

Who will take charge of the situation if a reaction occurs? _____

Where will the medications needed for a reaction be kept? (Recommend in the same room or location as the child) _____

Where in the program will the child receive care when a reaction occurs? _____

_____

What will the staff do if the child is?
...On the playground? _____
...On a field trip? _____

Where will the medications be kept while on a field trip: _____

Who will call the Emergency Medical System (911)? _____

Who will call the parents/guardian? _____

Who will go with the child to the hospital and stay until the parents can assume responsibility?

_____

Who will care for the other children if the caregiver must take the allergic child away from the group? _____

Is the allergy **with** the child's picture prominently posted in the kitchen **and** the eating area?
Yes / No

TRAINED CHILD CARE PROVIDERS: (Must be reviewed with any changes in the plan, if needed, attach more signatures to this form)

1. _____ Date: ____/____/____
2. _____ Date: ____/____/____
3. _____ Date: ____/____/____
4. _____ Date: ____/____/____
5. _____ Date: ____/____/____

Plan of care written in collaboration with:
Director: _____ Date: ____/____/____

Projected date of plan re-evaluation: (Reviewed and signed by licensed physician, psychiatrist, psychologist, or consulting psychologist at least annually) Date: ____/____/____

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)								

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)

DEPARTMENT OF EDUCATION

2022-2023 District Parent Letter | Ethnic and Racial Demographic Designation Form

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Dear Parent or Guardian:

In an effort to assist Minnesota districts in providing targeted programs and services to help all students succeed, districts are required by law to request more detailed student ancestry or ethnic origin information based on Minnesota's largest groups, beyond what has been collected on enrollment forms under federal law since 2008. Parents or guardians are not required to answer the federal questions (in bold) on the Ethnic and Racial Demographic Designation Form for their children. However, if you choose not to answer the federal questions (in bold), federal law requires schools to choose for you. State questions are labeled as "Optional" and schools will not fill in this information for you. Refusal to respond will not impact enrollment in the school.

As a result of the new law, you are asked to report your child's information. Starting with the 2019-20 school year, all schools in Minnesota will collect this information using these updated categories. The Minnesota Department of Education will continue to incorporate feedback from the public into this form.

To report your child's information, please complete the enclosed form and return it to Legacy of Dr. Josie R. Johnson Montessori by Tuesday, September 6, 2022. Note: You may choose to not indicate any of the more detailed selections by marking the "decline to indicate" option(s). You may also choose to mark an "other" option if you do not see your group represented. School staff are not required to assign students to these detailed groups.

Please complete and return the enclosed form. For more information about the reporting categories, please contact the Front Office at 612-302-3410.

Sincerely,

Tonicia Abdur Salaam

Head of School

DEPARTMENT OF EDUCATION

Reset form

Ethnic and Racial Demographic Designation Form

Student's First Name: _____ Middle Name/Initial: _____ Last Name: _____

Date of Birth: _____ District: _____ School: _____

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*):

☐ Decline to indicate	☐ Guatemalan	☐ Salvadoran	☐ Other Hispanic/Latino
☐ Colombian	☐ Mexican	☐ Spaniard/Spanish/ Spanish-American	☐ Unknown
☐ Ecuadorian	☐ 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*):

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

Go to Question 2.

[1]Federal 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 _____

Print/Save

DEPARTMENT OF EDUCATION

2022-2023 Student Digital Equity Survey

Survey Information

Thank you for participating in the Student Digital Equity Survey. This survey collects information on student access to the Internet and electronic devices used for schoolwork in the student's home. Legacy of Dr. Josie R. Johnson Montessori may use this information to identify students that could benefit from additional supports to make sure they can access learning opportunities outside the classroom or school building. It is important that we gather accurate information from every student so that each student and family has the equipment, help and support needed.

The information you provide in this survey will be reported to the Minnesota Department of Education (MDE). MDE may provide state- or school-level summary data—without personal, identifying information—to the Governor, legislators, agency staff and external partners who have established data sharing agreements and protocols. Legacy of Dr. Josie R. Johnson Montessori will not share your personal, identifying information provided in this survey with others without your consent.

Instructions

Please fill in the following information based on how you use electronic devices to complete schoolwork at your home. This survey uses the primary address you provide as your "home." **You should answer the questions below based only on the conditions at this address.** There is an opportunity at the end of the survey to say more about additional places you live and do homework.

Student Information

First name: _____

Last name: _____

Grade: _____

Student Primary Address: _____

Digital Device Access

1. ***Does the student use an electronic device like a computer, tablet or smart phone to complete homework?***

   No (skip to question 2)
   Yes (continue to 1a)

   a. ***If yes, what type of electronic device does the student usually use to complete homework?***

      (select ONLY one)

      ☐ Desktop or Laptop
      ☐ Tablet
      ☐ Chromebook
      ☐ Smart phone
      ☐ Other

   b. ***Is the electronic device (from 1a) provided by the school?***

      ☐ Yes
      ☐ No

   c. ***Is the electronic device shared with anyone else in the home?***

      ☐ Yes
      ☐ No

Internet Access

2. ***Can the student access the Internet on their electronic device at home?***

   ☐ No – Internet is **not** available at home (skip to end of survey)
   ☐ No – Internet is **not** affordable at home (skip to end of survey)
   ☐ No – Other (skip to end of survey)
   ☐ Yes (continue to 2a)

   a. ***If yes, what kind of Internet service do you have at home?***

      ☐ Residential broadband (e.g. Cable, Fiber, DSL)
      ☐ Cellular network
      ☐ School-provided hotspot
      ☐ Satellite
      ☐ Dial-up
      ☐ Other
      ☐ I am not sure.

   b. ***Can the student stream a video on their electronic device without pauses?***

      ☐ Yes – with **no** pauses or buffering
      ☐ Yes – with **some** pauses or buffering
      ☐ No – streaming doesn't work

      What else would you like us to know about Internet or device access at this or another place?

Brightwheel

2022-2023 Registration Fee | *Toddler & Preschool*

Introducing Brighwheel

Dear Parents,

We utilize the app Brightwheel, a tool for classroom management, communication, photos, videos, online bill pay, and much more. Brightwheel is the industry leader in early education, proven to save time for staff, allowing for measurably more time with students, while also delivering a much better experience for parents.

Registration Fee - $60.00

The $60.00 registration fee is due with the submission of the Toddler & Preschool Enrollment Packet and may be paid by one of the following payment methods.

Please indicate the method of payment you would like utilize:

- ☐ Cash or Check paid to the order of Legacy of Dr. Josie R. Johnson Montessori
- ☐ Online payment through the Brightwheel App

I give permission to Legacy of Dr. Josie R. Johnson Montessori School to charge the $60.00 Registration Fee through the Brightwheel App. I understand that I will receive an emailed notification from Brightwheel to set up an account and payment method. I understand and agree that the registration fee is a one-time payment and is non refundable.

_____ _____

(Parent/ Guardian Signature) (Date)

Legacy of Dr. Josie R. Johnson Montessori

5140 Fremont Avenue North • Minneapolis, MN 55430 • Phone (612)-302-3410 • Fax (612)-302-5911 • office@jjlegacy.org • ww.jjlegacy.org

Brightwheel

Is My Billing Information Safe?

Billing Security


Written by Dana

Our engineers have included the highest levels of encryption on all customer information. The payment processor we have partnered with (Stripe) is certified as PCI Level 1, the most stringent level of certification available. See their security site for detailed information about the security measures they have in place. No one at brightwheel has any access to any customer banking records; and all families using brightwheel for payment have to go through a two step authentication process to verify their accounts.

All your data - whether for school, family, or billing - is secure with brightwheel. We take your trust very seriously and have invested a great deal to build the most reliable and secure platform in early education

https://help.mybrightwheel.com/en/articles/942376-is-my-billing-information-safe#:~:text=Our%20engineers%20have%20included%20the,stringent%20level%20of%20certification%20available.

Legacy of Dr. Josie R. Johnson Montessori

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Toddler & Preschool Tuition Rates | 2022

Toddler Community & Children's House (PreK)	***Enrollment Fee**** **$60 at Registration**	One-time fee per registration Nonrefundable

Toddler Community [16 mo. - 36 mo.]	***Tuition Rate****	**Full Day:** 9:00 AM – 4:00 PM **Half Day:** 9:00 AM – 12:45 PM
4 Days, Half Day [M/T/W/Th]	**$170/week**	
4 Days, Full Day [M/T/W/Th]	**$265/week**	
5 Days, Half Day [M/T/W/Th/F]	**$200/week**	
5 Days, Full Day [M/T/W/Th/F]	**$310/week**	

Children's House [3 yrs - 5 yrs]	***Tuition Rate****	**Full Day:** 9:00 AM – 4:00 PM **Half Day:** 9:00 AM – 12:45 PM
4 Days, Full Day [M/T/W/Th]	**$240/week**	
5 Days, Half Day [M/T/W/Th/F]	**$185/week**	
5 Days, Full Day [M/T/W/Th/F]	**$290/week**	

***Please note these tuition rates are subject to change in January 2023.**

Legacy of Dr. Josie R. Johnson Montessori
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04/01/2022

2022-2023 Legacy of Dr. Josie R. Johnson Scholarship Application | *Toddler & Preschool*

Legacy of Dr. Josie R. Johnson Montessori School is able to provide scholarships through the generosity of the Hiawatha Education Foundation and through individual donations to the Dr. House Scholarship Fund. Funds are limited and JJ Legacy is not able to meet all the demand for scholarship funding. In order to assist as many children as possible, families are required to first apply for other funding for which they are eligible before receiving JJ Legacy Scholarship funds.

Child(ren) applying for: **Date:** _____

Child's Name	Date of Birth mm/dd/yyyy	Parent/Guardian Name	Relationship to Child

If your family income falls below the limits or is currently participating in at least one of the programs listed below, you must apply for the following:

- **Child Care Assistance**
  https://www.thinksmall.org/for_parents_and_guardians/paying_for_childcare/
- **Early Learning Scholarship information**
  https://www.thinksmall.org/for_parents_and_guardians/paying_for_childcare/early_learning_scholarships/

If your family income doesn't fall below the limits, your family may still be eligible for a JJ Legacy Scholarship.

INCOME INFORMATION

Families have an annual gross income of no more than 185% of Federal Poverty Guidelines.

Family Size	Gross Income	Family Size	Gross Income
2	$31,894	6	$65,046
3	$40,182	7	$73,344
4	$48,470	8	$80,346
5	$56,758	9**	$81,662

****For family units of more than nine members, add $8,288 for each additional member.**

OR

Currently participates in at least one of the following programs:

- MFIP
- CCAP
- Free and Reduced-Price Lunch Program (FRLP)
- CACFP (by income)
- Food Distribution Program on Indian Reservations
- SNAP
- Head Start
- Foster Care. (Note: applications for children in foster care must be signed and submitted by the county worker).

Legacy of Dr. Josie R. Johnson Montessori

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2022-2023 Legacy of Dr. Josie R. Johnson Scholarship Application | *Toddler & Preschool*

FAMILY FINANCIAL INFORMATION - SECTION 1

List family members the child lives with (adults and children):

Name	Relationship to child	Age (if a child)

PRIMARY HOUSEHOLD INFORMATION

Student's Primary Street Address: _____ City: _____ Zip Code_____

Primary Parent/Guardian Name #1_____

Best Phone Number _____ E-mail* _____

Primary Parent/Guardian Name #2_____

Best Phone Number _____ E-mail* _____

Child(ren) Race/ Ethnicity: _____

Child(ren) live(s) with (Check one):

☐ Both Parents/ Guardians (in same household)	☐ Parent/Guardian 1 (Primary or sole physical custody)**	☐ Shared Parenting Time (Shared physical custody)

**List Monthly Child Support received: $_____

Who is responsible for paying childcare costs* (Check one)?
*Please note that JJ Legacy holds both parents responsible for tuition payments.

☐ Both Parents/ Guardians	☐ Parent/Guardian 1	☐ Parent/ Guardian 2

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FAMILY FINANCIAL INFORMATION - SECTION 2

Please provide copies of the following:

- ❑ Two months of recent check stubs for both parents
- ❑ A copy of last year's tax return for both parents
- ❑ Child Care Assistance: Authorization letter, waitlist letter or denial letter [if applicable]
- ❑ Early Learning Scholarship Award letter and Award Planning Agreement [if applicable]
- ❑ 2022-2023 Application for Educational Benefits (MDE form - Available July 2022)

How much can you afford to pay weekly (per child)? $_____

What else would you like us to know?
Please give a brief description of any circumstances or information that would help us better understand your family needs. You may include any relevant information about your financial situation that you would like us to consider when reviewing your application.

_____

_____

_____

_____

_____

_____

Any present or prospective JJ Legacy family may apply for the JJ Legacy Scholarship. Scholarships are granted on the basis of need and the basis of first-come-first-serve at the discretion of the Scholarship committee. Parents will be notified in writing of scholarship awards. Parents are responsible for reporting any changes in family size or income. Scholarships may be decreased or eliminated at the discretion of the Scholarship committee.

Thank you for completing this application.

Staff Use Only Date Rcvd:_____	*Enrolled: Y/N*	❑ *Tax forms*	❑ *CCAP docs*	❑ *ELS docs*	❑ *App Ed Benefits*

Legacy of Dr. Josie R. Johnson Montessori

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Early Childhood Screening

When your child turns 3, it's time to screen for FREE!

Early Childhood Screening is a check up on how your child is growing and developing. All children must be screened before they start kindergarten.

It's best to screen children when they turn 3 years old, but screening can also be done at age 4 or 5.

At your child's screening, trained staff will check your child's:

- Vision and hearing
- Height, weight and growth
- Movement and balance
- Thinking, language and communication skills
- Social and emotional growth
- Immunization (shots) records

NOTE: If you are concerned about how your child is doing, call right away. Screening can be done for children at any age, even from birth to age 3.

Three reasons to screen at age 3:

1. Screening helps your child be ready for school.
2. Any health or learning concerns are found earlier and resources provided sooner.
3. Your family will learn about community resources that are available to your family.

When your child is 3 years old:

- **Set up a FREE screening appointment.** Call **(612) 668.3715** or schedule online at **ece.mpls.k12.mn.us/screen**.
- **Complete the health forms** that will be sent to you and bring them to the appointment.
- **Bring your child to the screening appointment.** Let us know if you need help with transportation.

SCHEDULE A SCREENING APPOINTMENT ONLINE AT

ece.mpls.k12.mn.us/screen

Click on the Screen at 3 logo below:

SCREEN AT 3

NEED TRANSPORTATION?

Call **612.668.3715** if you need help with transportation to and from the screening appointment.

CONTACT US

3345 Chicago Ave. S., Minneapolis, MN 55407

612.668.3715 | screen@mpls.k12.mn.us | ece.mpls.k12.mn.us/screen

Department of Early Childhood Education

FOLLOW US!

January 2019

What to Expect at your Child's Screening

Your child's physical development will be checked.

Your child's vision and hearing will be checked.

Your child will do activities to see how they are developing.

At the end of the screening, you will know how your child is developing.

If there are any areas where your child could use more support, our staff will work with you to find the right resources for your child.

Department of
Early Childhood Education

Minneapolis Public Schools
1250 W. Broadway Ave.
Minneapolis, MN 55411
Ph: 612.668.2140 | Fax: 612.668.2146
ece.mpls.k12.mn.us