LEGACY OF
Dr. Josie R. Johnson
MONTESSORI

2022-2023

Kindergarten

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

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LEGACY OF Dr. Josie R. Johnson MONTESSORI

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2022-2023 Application for Enrollment | *Kindergarten – 6th Grade*

Legacy of Dr. Josie R. Johnson Montessori Elementary School 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 Elementary School, please complete the application below and submit it by mail, in person, or by fax (*please see the contact information listed above).* Please submit your application by March 31, 2022 (Any applications submitted after this date will be added to the waitlist).

*****If your child is currently enrolled in Preschool, you MUST complete an Elementary application to apply for Kindergarten for the 2022-2023 school year - your child will not be automatically enrolled.*****

Student Information (*please print clearly*)

Last Name _____ First Name _____

Street Address _____

City / State / Zip _____

Grade for 2022-2023 School Year (*please circle one*) K* 1 2 3 4 5 6

*(*To be eligible for Kindergarten, your child must be 5 years old by September 1, 2022.)*

Parent / Guardian Information (*please print clearly*)

Parent / Guardian 1 _____

E-mail Address _____ Phone _____

Parent / Guardian 2 _____

E-mail Address _____ Phone _____

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 Elementary 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 Elementary School on the basis of gender, religion, ethnicity, immigrant (legal or non) status, or intellectual or physical ability. Legacy of Dr. Josie R. Johnson Montessori Elementary School is a charter public school and is tuition-free. Students from all backgrounds are encouraged to apply.

If more people apply than the number of spaces available for a given grade, program, or facility, Legacy of Dr. Josie R. Johnson Montessori Elementary School will conduct a public lottery to determine admittance to the school. The only preference we give in admitting students is for children who are siblings of current Legacy of Dr. Josie R. Johnson Montessori Elementary School students or children of Legacy of Dr. Josie R. Johnson Montessori School staff. In order to get this preference, parents MUST submit an application before the end of the open enrollment period. The lottery will be held on Tuesday, April 26, 2022, at 5:00 p.m.

(LJJM Office Use) Date Received:_____ Notice of Enrollment Sent on Date:_____

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2022-2023 Enrollment Form | *Kindergarten – 6th Grade*

STUDENT INFORMATION

GRADE ENTERING in September 2022: _____
A Kindergartener is a child age five by September 1 of the school year

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

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

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

Sex (circle one): Male | Female Date of Birth: _____ Age: _____ Grade: _____ Place of Birth: _____

Last School Attended: _____ Address: _____

Dates of Attendance at last school: _____ Has the student attended Legacy of Dr. Josie R. Johnson Montessori in the past? Yes | No

Does the student have a sibling who currently attends Legacy of Dr. Josie R. Johnson Montessori ?:
_____

If yes, sibling's name(s): _____

Is a sibling of this student applying for enrollment for the 2022-23 school year? _____

If yes, sibling's name(s): _____

PRIMARY HOUSEHOLD INFORMATION
List only parent/guardians who reside at this address

Address including zip: _____

Primary Parent/Guardian Name #1: _____

Relationship to student: _____

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

Email: _____

Primary Parent/Guardian Name #2: _____

Relationship to student: _____

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

Email: _____

Student lives at this address? Yes | No If yes, Full Time: _____ or Part Time: _____

Language(s) spoken at home: _____

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Student's Name: _____

SECONDARY HOUSEHOLD INFORMATION
List only parent/guardians who reside at this address

Address including zip: _____

Primary Parent/Guardian Name #1: _____

Relationship to student: _____

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

Email: _____

Primary Parent/Guardian Name #2: _____

Relationship to student: _____

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

Email: _____

Student lives at this address? Yes | No **If yes, Full Time:** _____ **or Part Time:** _____

Language(s) spoken at home: _____

NON-HOUSEHOLD EMERGENCY CONTACTS

	Name of Contact	Phone Number	Relationship to Student	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

Parental Permission: By listing the contacts above, you give Legacy of Dr. Josie R. Johnson Montessori 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 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.

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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

**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)

*******A BIRTH CERTIFICATE AND IMMUNIZATION RECORD IS REQUIRED FOR ALL STUDENTS ENROLLING*******

Enrollment of Families and Youth in Transition: The McKinney Vento Homeless Assistance Act, reauthorized in December 2001, ensures educational rights and protections for children and youth experiencing homelessness. Legacy of Dr. Josie R. Johnson Montessori Montessori School provides immediate enrollment despite not having all required documents which are normally obtained prior to enrollment. Students may apply at any time. **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

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

Birth Date: _____/_____/_____ **Sex (circle one):** Male | Female

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? 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? 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? 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: Yes | No

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

Medical Assistance Number: _____

HEALTH CARE PROVIDERS:

Does your child have a doctor or clinic where they usually go for health care?: Yes | No
Does your child have a dentist or clinic where they usually go for dental care?: Yes | No

Doctor Name: _____ Clinic Name: _____ Policy: _____

Dentist Name: _____ Clinic Name: _____ Policy: _____

Medical Ins. Co: _____ Clinic Number: _____ Policy: _____

Medical Assistance Number: _____

Hospital preference in case of emergency: _____

This health information may be shared with JJ Legacy staff as needed. If you do not want this health information shared, please contact the office. 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 Name: _____ **Phone Number:** _____
(please PRINT name)

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

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

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

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

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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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Request for Student Records | Change in Enrollment

The following student has registered at Legacy of Dr. Josie R. Johnson Montessori Montessori School (4189):

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

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

Sex (circle one): Male | Female **Date of Birth:** _____ **Grade:** _____ **MARSS ID:** _____

Anticipated Enrollment Date: _____

Previous School Information:

Last School Attended: _____ **Address:** _____

School Phone Number: _____ **School Fax Number:** _____

Previous School - Please forward the following information:,

- Transcripts of records and grades - all academic records
- Special Education records – including IEP/504 Plan or other assessments
- Standard Test Results
- Legal Documents
- Attendance Records
- Discipline Records
- Health Records – including Immunizations
- ELL/ESL Records
- MARSS ID #

1st Request: _____

2nd Request: _____

3rd Request: _____

According to the Final Regulations-Family Educational Rights and Privacy Ace (Buckley Amendment) dated June 17, 1976, it is no longer necessary to obtain written consent to release records between schools. It also states school officials, including teachers within educational institutions, and officials of other schools in school systems on which the students may intend to enroll, may receive student's records without a written consent for such a release.

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.

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

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SY 22-23 Transportation Request

Date of Request: _____

Requested Effective Date: _____

Please fill out all information for each child:

Student Name	Date of Birth	Grade

Home Address including zip: _____

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

Pickup Location (In morning where your child is coming from)

❑ No transportation Needed ❑ Home ❑ Daycare/Alternative location

Address: _____

Contact: _____

Phone: _____

Drop Location (In afternoon where your child is going to)

❑ No transportation Needed ❑ Home ❑ Daycare/Alternative location

Address: _____

Contact: _____

Phone: _____

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Minnesota Language Survey
for All New Kindergarten and Incoming Students

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: _____
(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 | *Kindergarten – 6th Grade*

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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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.

Please describe your child's previous experience 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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Please provide a brief description of your child's eating habits, sleeping patterns and communication style.

Please share with us anything else you would like us to know about your child.

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

DEPARTMENT OF EDUCATION

LEGACY OF Dr. Josie R. Johnson MONTESSORI

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

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

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

LEGACY OF Dr. Josie R. Johnson MONTESSORI

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 School 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 School 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?

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: ____/____/____

Immunization Form

Name_____ Birthdate_____

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.

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)

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

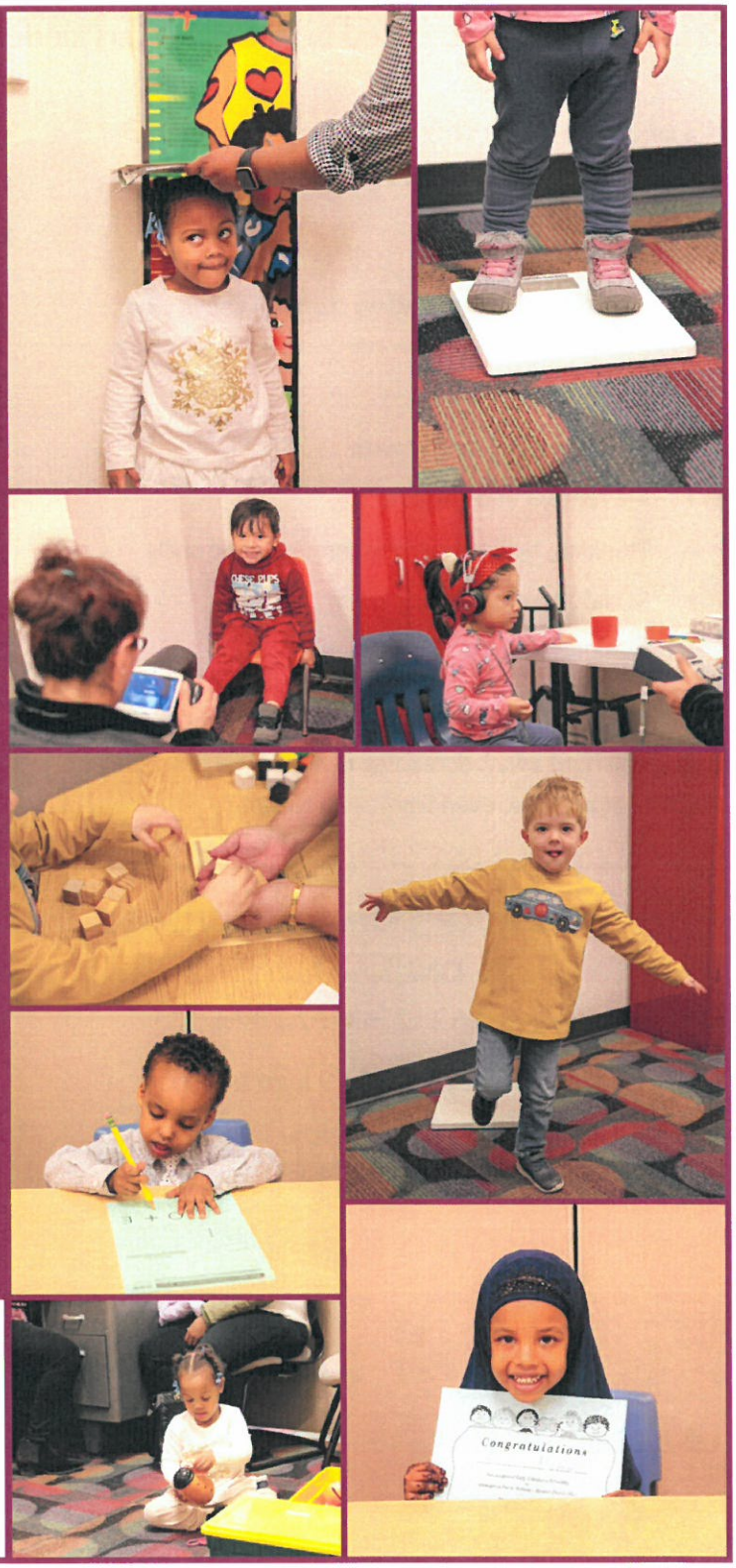
Your child's physical development will be checked.

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

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LEGACY OF
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MONTESSORI

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2022-2023 Enrollment Checklist | *Kindergarten*

- ❑ 2022-2023 Application for Admission
- ❑ My Child's Story
- ❑ 2022-2023 Enrollment Packet (includes the following):
  - _ Student Information Form
  - _ Emergency contacts Form
  - _ Special Services Form
  - _ Health & Wellness Form
  - _ Race & Ethnicity Form
  - _ Photo Release and Field Trip Permission Form
  - _ Transportation Request Form
  - _ School Records Request
  - _ Minnesota Language Survey
- ❑ Student Digital Equity Survey
- ❑ Ethnic and Racial Demographic Designation form
- ❑ **Health Care Summary Form (Must be completed and signed by Pediatrician)**
- ❑ **Individual Child Care Program Plan (Must be completed regardless of allergies)**
- ❑ **Copy of Immunization Records**
- ❑ **Copy of Birth Certificate**
- ❑ **Copy of Early Childhood Screening records**
- ❑ 2022-2023 Application for Educational Benefits *(MDE form - Coming July 2022)*

Please submit your completed forms and documents by one of the following methods:

Mail / In-person: 5140 Fremont Avenue North, Minneapolis, MN 55430

Email: office@jjlegacy.org

Fax: 612-302-5911

02/01/2022