



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: _____

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 • www.jjlegacy.org



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)		Preschool (3 to 5 years): ___5 days/week (Mon-Fri) (OR) ___4 days/week (Mon-Thu)**	
___ Half Day with Lunch	9:00am - 12:45pm*	___ Half Day with Lunch	9:00am - 12:45pm*
___ Full Day	9:00am - 4:00pm*	___ Full Day	9:00am - 4:00pm*
*Schedules subject to change.		*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.*



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		<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		Yes / No
2		<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		Yes / No
3		<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> 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: _____



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

	Name of Contact/ Relationship to Student	Phone Number	Driver's License #	Authorized to Pick up?
1		<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		Yes / No
2		<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		Yes / No
3		<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		Yes / No
4		<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		Yes / No
5		<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		Yes / No
6		<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		Yes / No
7		<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		Yes / No
8		<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		Yes / No
9		<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		Yes / No
10		<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> 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: _____



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.



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



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: ____/____/____



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: _____



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)



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?



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:	<input type="checkbox"/> language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> only English.	
2. My student speaks:	<input type="checkbox"/> language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> only English.	
3. My student understands:	<input type="checkbox"/> language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> only English.	
4. My student has consistent interaction in:	<input type="checkbox"/> language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> only English.	

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

Parent/Guardian 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.



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?



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.



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

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?



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:

- **dress**ing
- **undress**ing
- **eat**ing
- **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: 612-302-5911

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:

- Mouth
- Throat*
- Skin
- Gut
- Lung*
- Heart*

Symptoms:

itching and swelling of the lips, tongue, or mouth
itching and/or a sense of tightness in the throat, hoarseness and hacking cough
hives, itchy rash, and/or swelling about the face or extremities
nausea, abdominal cramps, vomiting, and/or diarrhea
shortness of breath, repetitive coughing, and/or wheezing
"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 _____

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

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.

Name:

Birthdate

Birthdate

[illegible]

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.

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

Name _____

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

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

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

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

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

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

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

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

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

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

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)

Notary Stamp

by _____
(name of parent or guardian)

Notary Signature: _____

STATE OF MINNESOTA, COUNTY OF _____

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)



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 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,

A handwritten signature in black ink, appearing to read 'Tonicia Abdur Salaam'.

Tonicia Abdur Salaam

Head of School

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*):

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

Go to Question 1.

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

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

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

☐ **No** [If no, go to Question 2.]

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

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

Go to Question 2.

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

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

☐ **Yes** [Go to Question 3.]

☐ **No** [Go to Question 3.]

Question 3. Is the student Asian as defined by the federal government? The federal definition includes persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.¹

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

☐ **No** [If no, go to Question 4.]

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

- | | | | |
|--|-----------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Decline to indicate | <input type="checkbox"/> Chinese | <input type="checkbox"/> Karen | <input type="checkbox"/> Other Asian |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Filipino | <input type="checkbox"/> Korean | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Burmese | <input type="checkbox"/> Hmong | <input type="checkbox"/> 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*):

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Decline to indicate | <input type="checkbox"/> Ethiopian-Other | <input type="checkbox"/> Somali |
| <input type="checkbox"/> African-American | <input type="checkbox"/> Liberian | <input type="checkbox"/> Other black |
| <input type="checkbox"/> Ethiopian-Oromo | <input type="checkbox"/> Nigerian | <input type="checkbox"/> 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



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?



Dear Parent/Guardian:

Our school provides healthy meals each day. Breakfast costs \$2.35; Lunch costs \$3.87.

Your children may qualify for free or reduced-price school meals. To apply, complete the enclosed Application for Educational Benefits following the instructions. A new application must be submitted each year. At public schools, your application also helps the school qualify for education funds and discounts.

State funds help to pay for reduced-price school meals, so all students who are approved for either free or reduced-price school meals will receive school meals at no charge. State funds also help to pay for breakfasts for kindergarten students, so all participating kindergarten students receive breakfasts at no charge.

Return your completed Application for Educational Benefits to:

Legacy of Dr. Josie R. Johnson Montessori School 5140 Fremont Avenue North, Minneapolis, MN 55430

Who can get free school meals? Children in households participating in the Supplemental Nutrition Assistance Program (SNAP), Minnesota Family Investment Program (MFIP) or Food Distribution Program on Indian Reservations (FDPIR), and foster, homeless, migrant and runaway children can get free school meals without reporting household income. Alternatively, children can get free school meals if their household income is within the maximum income shown for their household size on the instructions.

To apply for free school meals, please complete the Application for Educational Benefits form.

COMMON QUESTIONS:

I get WIC or Medical Assistance. Can my children get free school meals? Children in households participating in WIC or Medical Assistance do not automatically qualify for free meals. Children may be eligible for free or reduced-price school meals depending on other household financial information. Please fill out an application.

Who should I include as household members? Include yourself and all other people living in the household, related or not (such as grandparents, other relatives, or friends).

May I apply if someone in my household is not a U.S. citizen? Yes. You or your children do not have to be U.S. citizens for your children to qualify for free or reduced-price school meals.

What if my income is not always the same? List the amount that you normally get. If you normally get overtime, include it, but not if you get overtime only sometimes. For seasonal work, write in the total annual income.

Will the income information or case number I give be checked? It may be. We may also ask you to send written proof.

How will the information be kept? Information you provide on the form, and your child's approval for meal benefits, will be protected as private data. For more information see the back page of the Application for Educational Benefits.

If I don't qualify now, may I apply later? Yes. Please complete an application at any time if your income goes down, your household size goes up, or you start getting SNAP, MFIP or FDPIR benefits.

Please provide the information requested about children's racial identity and ethnicity, which helps to make sure we are fully serving our community. This information is not required for approval of school meal benefits.

If you have other questions or need help, call **612-302-3410**.

Sincerely, **JJ Legacy Administration Team**

How to Complete the Application for Educational Benefits

Complete the Application for Educational Benefits form for school year 2022-23 if any of the following applies to your household:

- Any household member currently participates in the Minnesota Family Investment Program (MFIP), or the Supplemental Nutrition Assistance Program (SNAP), or the Food Distribution Program on Indian Reservations (FDPIR) or
- The household includes one or more foster children (a welfare agency or court has legal responsibility for the child) or
- The total income of household members is within the guidelines shown below (**gross earnings before deductions**, not take-home pay). Do not include as income: foster care payments, federal education benefits, MFIP payments, or value of assistance received from SNAP, WIC, or FDPIR. Military: Do not include combat pay or assistance from the Military Privatized Housing Initiative. The income guidelines are effective from July 1, 2022 through June 30, 2023.

Maximum Total Income

Household size	\$ Per Year	\$ Per Month	\$ Twice Per Month	\$ Per 2 Weeks	\$ Per Week
1	25,142	2,096	1,048	967	484
2	33,874	2,823	1,412	1,303	652
3	42,606	3,551	1,776	1,639	820
4	51,338	4,279	2,140	1,975	988
5	60,070	5,006	2,503	2,311	1,156
6	68,802	5,734	2,867	2,647	1,324
7	77,534	6,462	3,231	2,983	1,492
8	86,266	7,189	3,595	3,318	1,659
Add for each additional person	8,732	728	364	336	168

Step 1: Children

List all infants and children in the household, their school and grade if applicable, and birthdate. Attach an additional page if needed to list all children. Check the box if a child is in foster care (a welfare agency or court has legal responsibility for the child).

Step 2: Case Number

If any household member currently participates in SNAP, MFIP or FDPIR, write in the case number and then go to Step 4. If you do not participate in any of these programs, leave Step 2 blank and continue on to Step 3.

Step 3: Adult and Child Incomes / Last 4 Digits of Social Security Number

- **Social Security Number/Total Household Members.** An adult household member must provide the last four digits of their Social Security number or check the box if they do not have a Social Security number. Report the total number of household members and ensure all household members are listed individually on the application in the child or adult section as applicable.
- **Child Income.** If any children in the household have regular income, such as SSI or part-time jobs, list the total amount of regular incomes received by all children, and check the box for the frequency: weekly, bi-weekly, twice a month, or monthly. Do not include occasional earnings like babysitting or lawn mowing.
- **Adult income.** Report the names of adult household members and income earned in this section.
 - List all adults living in the household not listed in Step 1, whether related or not, such as grandparents, relatives, or friends.
 - **Gross Earnings from Work.** This is usually the money received from working at jobs where a paycheck is received. For each income, check the box to show how often the income is received: weekly, bi-weekly, twice per month, or monthly.
 - List gross incomes before deductions, not take-home pay. Do not list an hourly wage rate. For adults with no income to report, enter a '0' or leave the section blank. For seasonal work, write in the total annual income.
 - **Are you Self-Employed or a Farmer?** List the net income per month or year after business expenses. Do not list the same income twice on the application. A loss from farm or self-employment must be listed as 0 income and does not reduce other income.
 - **Any Other Gross Income.** List gross incomes before deductions from all other sources, such as SSI, unemployment, child support, public assistance, social security, rental income or annuities.

Step 4: Signature and Contact Information An adult household member must sign the form. If you do not want your information to be shared with Minnesota Health Care Programs, check the "Don't share" box in Step 4.

Optional: Please provide the information on ethnicity and race that is requested on the second page of the form. This information is not required and does not affect approval for school meal benefits. The information helps to ensure we are meeting civil rights requirements and fully serving our community.



2022-23 Application for Educational Benefits

Complete one application per household for all children. Please use pen (not a pencil). **Mail or return completed form to: Legacy of Dr. Josie R. Johnson Montessori School 5140 Fremont Ave. N, Minneapolis, MN 55430**

STEP 1: List ALL Household Members who are infants, children, and students up to and including grade 12 (if more spaces are required for additional names, attach another sheet of paper).

Definition: A Household Member is "Anyone living with you and shares income and expenses, even if not related." Children in Foster care are eligible for free meals. Read *How to Complete the Application for Educational Benefits* for more information. Adults over grade 12 living in the same household should be reported in Step 3. If your children attend different districts or charter/nonpublic schools, return an application at each one.

Child's First Name (list all children in household)	MI	Child's Last Name	School	Grade	Birthdate	Foster Child (v)
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>

STEP 2: Do Any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP, MFIP or FDIPIR? Medical assistance **does not** qualify. **IF NO > Go to STEP 3.**
If YES > Enter SNAP, MFIP or FDIPIR Case Number (between 4-9 digits, do not report EBT card number) _____ then go to STEP 4 (Do not complete STEP 3)

STEP 3: Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

A. Last Four Digits of Social Security Number (SSN) of Adult Household Member: XXX-XX-____ Or Check if Adult has No SSN: ☐ Total Number of All Household Members (Children + Adults) ☐

B. Child Income.

Total Income Received by All Children	Weekly	Bi-weekly	2x Month	Monthly
\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Sometimes children in the household earn or receive income, such as from a part time job or SSI. Please include the TOTAL income received by all children listed in STEP 1. Do not include income received by adults in the box to the right.

Names of All Adult Household Members (First and Last)		Gross Earnings from Working at Jobs			Are you Self-Employed or a Farmer?		Any Other Gross Income			
List all Household members not listed in STEP 1 (including yourself) even if they do not receive income. Include children who are temporarily away at school or in college.		Weekly	Bi-Weekly	2x Month	Monthly	Net income from Farm or Self-Employment. Do not duplicate elsewhere.	Yearly	Monthly	Bi-Weekly	2x Month
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STEP 4: Contact information and adult signature. "I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

☐ I have checked this box if I do not want my information shared with Minnesota Health Care Program as allowed by state law.

Printed name of adult signing form _____ Daytime Phone _____
Address (if available) Apt# _____ City _____ Zip _____

SIGN HERE: Signature of Household Adult _____ Date _____

Do Not Fill Out: For School Office Use Conversions to Annualize All Income:		X1	X12	X24	X26	X52
All Total Income (Include child and adult income)		Annualize	Monthly	2X Month	Bi-weekly	Weekly
\$		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Determine Official Signature:		Household Size:		Free	Reduced	Denied
Confirming Official Signature:		Household Eligibility		Free	Reduced	Denied
		Date:		Date:		

OPTIONAL: Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced price meals. Respond to both Step One, *Ethnicity* and Step Two, *Race*.

Step One: Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Step Two: Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

INSTRUCTIONS: Sources of Income

Sources of Income for Children

Sources of Child Income	Examples
<ul style="list-style-type: none">Earnings from workSocial SecurityDisability PaymentsSurvivor's BenefitsIncome from person outside the householdIncome from any other source	<ul style="list-style-type: none">A child has a regular full or part-time job where they earn a salary or wagesA child is blind or disabled and receives Social SecurityA Parent is disabled, retired, or deceased, and their child receives Social Security benefitsA friend or extended family member regularly gives a child spending moneyA child receives regular income from a private pension fund, annuity, or trust

Sources of Income for Adults

Earnings from Work	Public Assistance / Alimony / Child Support	All Other Income
<ul style="list-style-type: none">Salary, wages, cash bonuses (before deductions or taxes)Net income from self-employment (farm or business)If you are in the U.S. Military:<ul style="list-style-type: none">Basic pay and cash bonuses (do NOT include combat pay, FSSA or privatized housing allowances)Allowances for off-base housing, food and clothing	<ul style="list-style-type: none">Cash Assistance from State or local governmentSupplemental Security IncomeUnemployment benefitsWorker's compensationAlimony paymentsChild support paymentsVeteran's benefitsStrike benefits	<ul style="list-style-type: none">Social SecurityDisability benefitsRegular income from trusts or estatesAnnuitiesInvestment incomeRental incomeRegular cash payments from outside household

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

At public school districts, each student's school meal status also is recorded on a statewide computer system used to report student data to MDE as required by state law. MDE uses this information to: (1) Administer state and federal programs, (2) Calculate compensatory revenue for public schools, and (3) Judge the quality of the state's educational program.

Nondiscrimination statement: In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: (1) **mail:** U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; or (2) **fax:** (833) 256-1665 or (202) 690-7442; or (3) **email:** program.intake@usda.gov

This institution is an equal opportunity provider.



2022-2023 Enrollment Checklist | *Toddler & Preschool*

Section 1 - Enrollment Forms

ALL DHS MANDATED DOCUMENTS MUST BE ON FILE BEFORE CHILD MAY ATTEND

- ☐ 2022-2023 Application for Admission
- ☐ My Child's Story
- ☐ 2022-2023 Enrollment Packet (includes the following):
 - _ Student Information/ Emergency form
 - _ Special Services Form
 - _ Health & Wellness Form
 - _ Race & Ethnicity Form
 - _ Photo Release and Field Trip Permission Form
 - _ Transportation request form (Kindergarten only)
 - _ Minnesota Language Survey
- ☐ 2022-2023 Application for Educational Benefits (*Coming July 2022*)
- ☐ Student Digital Equity Survey
- ☐ Ethnic and Racial Demographic Designation form
- ☐ **Health Care Summary** (must be completed and signed by Pediatrician)
- ☐ **Copy of Immunization Records** (*please obtain from Pediatrician*)
- ☐ **Individual Child Care Program Plan**

This form must be completed for ALL enrolling preschool and Kindergarten students.

Please see below:

- Child with allergies: Parent/Guardian must complete the form and submit with a copy of the care plan prescribed and signed by physician
- Child with no allergies: Parent/Guardian must complete the form with Child's Name, indicate "no known allergies", and complete with parent/guardian signature and date

- ☐ **Copy of Birth Certificate**
- ☐ **Copy of Early Childhood screening results** (if applicable)



2022-2023 Enrollment Checklist | Toddler & Preschool

Section 2 - Financial Documentation

☐ **\$60.00 Registration Fee - due with submission of Enrollment packet**

☐ Child Care Assistance documentation *[if applicable]*

Child care assistance must be confirmed by case worker prior to program start date.

Please submit one of the following:

- ☐ Letter of authorization
- ☐ Waitlist Notification
- ☐ Denial Notification

☐ Early Learning Scholarship *[if applicable]*

- ☐ Award letter
- ☐ Award Planning Agreement

☐ JJ Legacy Scholarship Application *[if applicable]*

Please provide copies of the following:

- ☐ Two months of recent check stubs [from both parents if applicable]
- ☐ A copy of last year's tax return summary
- ☐ 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)

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

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

Email: office@jjlegacy.org

Fax: 612-302-5911



2022-2023 Registration Fee | *Toddler & Preschool*

Introducing Brightwheel

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)



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>



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

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



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).



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):

<input type="checkbox"/> Both Parents/ Guardians (in same household)	<input type="checkbox"/> Parent/Guardian 1 (Primary or sole physical custody)**	<input type="checkbox"/> Shared Parenting Time (Shared physical custody)
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**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.

<input type="checkbox"/> Both Parents/ Guardians	<input type="checkbox"/> Parent/Guardian 1	<input type="checkbox"/> Parent/ Guardian 2
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2022-2023 Legacy of Dr. Josie R. Johnson Scholarship Application |
Toddler & Preschool

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	<input type="checkbox"/> Tax forms	<input type="checkbox"/> CCAP docs	<input type="checkbox"/> ELS docs	<input type="checkbox"/> App Ed Benefits
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