Park Rapids Preschool
301 Huntsinger Avenue
Park Rapids, MN 56470
218-237-6600

Return form NO earlier than March 10, 2021

Office Use Only

Registration Date	Enrollment Date
Registration Time	Start Date Age

Programs Available:
Please mark a 1 for first choice and a 2 for second choice

Voluntary Pre-Kindergarten Program-No Tuition
____Full Day (8-3) Monday & Wednesday **OR** ____Full Day (8-3) Tuesday & Thursday
Child must be 4 as of September 1, 2021 and toilet trained for these classes.

3 Year Old Program-$65/per month
____2 Half Day (8-11) Monday & Wednesday **OR** ____2 Half Day (12-3) Monday & Wednesday
Child must be 3 as of September 1, 2021 and toilet trained for this class.

Legal Student First Name	**Legal Middle Name**	**Legal Last Name**		___Male ___Female	**Date of Birth**	**Resident District** School District where student lives
Student Address	**City**	**Zip**	**Home Phone**	**Early Childhood Screening Date**		**Is this child toilet trained?** ☐ YES ☐ NO

Legal Mother of Student			**Legal Father of Student**		
Name			Name		
Address			Address		
City	State	Zip	City	State	Zip
Employer			Employer		
Work Phone	Home/Cell Phone		Work Phone	Home/Cell Phone	
E-mail Address:			E-mail Address:		

Student Lives with:		***If other than parents**	
Both Parents		Name	
Mother		Address	
Father		City	MN Zip
Step-Parent		Employer	
Foster Parent		Work Phone	
Guardian		Would you like the school to send correspondence to non-custodial parent?	
Other			

Ethnicity

Is this student Hispanic/Latino?
_____ No, not Hispanic/Latino
_____ Yes, Hispanic/Latino

Race

No matter what you selected in the ethnicity question, please continue to answer the following by marking one or more boxes to indicate what you consider your student's race to be.
_____ 1 American Indian or Alaska
_____ 2 Asian
_____ 3 Black or African American
_____ 4 Native Hawaiian or Pacific Island
_____ 5 White

Home Language

First language learned by pupil_______________
Language normally used: By pupil at home ___________________________.
By parents at home_______________. By student with friends_______________.

During the day, the child is usually cared for by: (circle)

Mother

Father

Grandparent

Day Care Provider

Transportation

(There are limited transportation options for the 3 year old program, more info will be provided in the fall)

Do you anticipate your child will be:

_______ Dropped off & picked up to/from school
_______ Riding the bus to school
_______ Riding the bus home
_______ Riding the bus to & from school
_______ Riding the bus from daycare to school
_______ Riding the bus to daycare from school

School Related Student Support Services

Check those services that this student receives from the school district

_______ Autism Spectrum Disorders (ASD)
_______ Deaf and Hard of Hearing (DHOH)
_______ Early Childhood Special Education (ECSE)
_______ Emotional or Behavioral Disorders (EBD)
_______ Occupational Therapy (OT)
_______ Physical Therapy (PT)
_______ Speech or Language Impairments (SP)
_______ Visually Impaired (VI)

Day Care Provider Information:
Name
Address
Phone

Yes☐ No☐ I give my permission to Head Start/ISD 309 to transport and/or obtain emergency medical and dental care for my child should he/she have an accident or need emergency medical or dental care beyond the scope of Head Start/ISD 309 staff.

Signature:____ Date:_____________________

Conditions which could be important in an Emergency:
___Mild/Severe Asthma
___Seizures/Convulsions
___Medication Allergies (list)

____

____

Food Allergies ____________________

____

Other Allergies ____________________

Heart Condition ____________________

Other __________________________

PREFERRED MEDICAL FACILITY/PERSONNEL TO BE USED IN AN EMERGENCY

Primary Health Care Provider
Essentia Health – Park Rapids
705 Pleasant Avenue
Park Rapids, MN 56470

Doctor's Name_____________________
If not Essentia Health-Park Rapids, list below
Clinic Name_____________________________

Address_____________________________

City_________________________________

Phone_________________________

Primary Dental Care Provider

Name
Address
City
Phone

Hospital Emergency Room

St. Joseph's Area Health Service
600 Pleasant Avenue
Park Rapids, MN 56470
218-732-3311
If not St. Joseph's, list below
Hospital Name_____________________________

Address_____________________________

City_________________________________

Phone_________________________

Local emergency contact persons if parent/guardian cannot be found or is delayed in arriving at school to pick up the child.

#1 Contact Name ____

Physical Address____

City_____________________________________ MN

Work Phone _______________________ Home Phone _______________________
Relationship to Child: ☐Grandparent ☐Aunt/Uncle ☐Brother/Sister
☐Step Parent ☐Other (list)_____________________________

#2 Contact Name ____

Physical Address____

City_____________________________________ MN

Work Phone _______________________ Home Phone _______________________
Relationship to Child: ☐Grandparent ☐Aunt/Uncle ☐Brother/Sister
☐Step Parent ☐Other (list)_____________________________

Is there anyone who is legally restrained from contact with your child?
Please provide a copy of the restraining order
Name:

This form must accompany the child, if he/she is taken to the clinic or hospital for emergency medical care.

PARENT AUTHORIZATION FOR PICK-UP/DROP-OFF: I give my permission for Head Start/Pals to release my child to the following persons; to include taking my child off the bus and picking up my child from **Head Start/Pals**. Attach additional names as needed or changes occur.

Name & Relationship	Address (Including City)	Work Phone/Home Phone/Message Number