

Mora Community Education Preschool Enrollment Form  
200-9<sup>th</sup> St. N Mora, MN. 55051  
320-679-6257

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Legal Name (first middle last): \_\_\_\_\_

Name you would like us to call your child: \_\_\_\_\_

Dear Parent or Guardian,

Please read carefully before you begin completing this application form. The application will be considered complete when all supporting information is provided and the **\$25.00 Application Fee** is paid. The information you provide will be treated confidentially and used only for Early Childhood Programming.

We are asking that everyone fill out pages 1 through 5 and if you are applying for a scholarship, please also fill out pages 6 & 7 along with providing proof of income (ex. copy of your 2019-1040 tax form).

If you have any questions about the application process,  
please call 320-679-6257.

Office use only

Date received _____	Time received _____	Application fee _____
Financial Aid application _____	Proof of Income _____	Application complete _____
Monthly Tuition _____	Financial Aid Award _____	

# Mora Community Education Preschool Class Choices:

Preschool Classes will be held in the Early Childhood Wing  
at Mora Elementary School, door A4

Four-year-olds (4 by Sept. 1, 2020)

Three-year-olds (3 by Sept. 1, 2020)

\_\_\_\_\_ Mon/Wed/Fri (8:15-2:30)  
(cost is \$270.00/month)

\_\_\_\_\_ Tues/Thurs AM (8:15-11:00)  
(cost is \$75.00/month)

\_\_\_\_\_ Mon/Wed/Fri AM (8:15-11:00)  
(cost is \$112.00/month)

\_\_\_\_\_ Tues/Thurs PM (11:45-2:30)  
(cost is \$75.00/month)

\_\_\_\_\_ Tues/Thurs (8:15-2:30)  
(cost is \$180.00/month)

\_\_\_\_\_ Mon/Wed PM (11:45-2:30)  
(cost is \$75.00/month)

## **The following information is for Four-Year-old classes only:**

“Extended Day” (an after school childcare)

is available and will be provided by Early Childhood staff.

Cost is \$14.00/month for T/TH students and \$21.00/month for M/W/F students.

This service is available from 2:30-3:15 PM.

This service will be only offered to a minimum of 7 children and a maximum of 10.

\_\_\_\_\_ Yes please, I would like my child to participate in the Extended Day Program

\_\_\_\_\_ No thank you, my child will be picked up at the end of preschool

Breakfast and lunch will be free for students who qualify under the Educational Benefits Program. Please be sure to fill out the application on-line (information will be provided at Open House and/or

Preschool Orientation), regardless, the information you supply benefits our school district as a whole. You will receive a letter from the school if you qualify. Those who do not qualify, you will still be able to purchase breakfast and/or lunch at the current price.

\_\_\_\_\_ Yes please, I am interested in the breakfast program

\_\_\_\_\_ No thank you, my child will eat breakfast before coming to school

Child’s Legal Name: \_\_\_\_\_  
(Last) (First) (Middle)

Birth Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Month) (Day) (Year)

Sex: \_\_\_\_\_ F \_\_\_\_\_ M

Home Address for Child: \_\_\_\_\_  
(Street and/or Box number) (City) (Zip Code)

Home Phone Number: \_\_\_\_\_ Does student live in the Mora School District? \_\_\_yes \_\_\_no

Who does the child live with? \_\_\_Mother \_\_\_Father \_\_\_Mother & Father \_\_\_Other, see below (Please check all that apply)

**Biological Mother Information**

Mother: \_\_\_\_\_ D.O.B. \_\_\_\_\_ (for state reporting purposes)

Address (if different than student): \_\_\_\_\_  
(Street and/or Box number) (City) (Zip Code)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email address: \_\_\_\_\_ Employer: \_\_\_\_\_

**Biological Father Information**

Father: \_\_\_\_\_ D.O.B. \_\_\_\_\_ (for state reporting purposes)

Address (if different than student): \_\_\_\_\_  
(Street and/or Box number) (City) (Zip Code)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email address: \_\_\_\_\_ Employer: \_\_\_\_\_

**Other Adult Information (If student lives with)**

Name: \_\_\_\_\_ Relation to student: \_\_\_\_\_

Address \_\_\_\_\_  
(Street and/or Box number) (City) (Zip Code)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email address: \_\_\_\_\_ Employer: \_\_\_\_\_

**Other Adult Information (If student lives with)**

Name: \_\_\_\_\_ Relation to student: \_\_\_\_\_

Address \_\_\_\_\_  
(Street and/or Box number) (City) (Zip Code)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email address: \_\_\_\_\_ Employer: \_\_\_\_\_

**Student/Family Information**

Please complete this section for **all** siblings of student, that live at the same residence.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Gender: M F \_\_\_\_\_  
DOB: \_\_\_\_\_  
M F \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ M F \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ M F \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**Health Information**

Primary Doctor: \_\_\_\_\_ Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist Name: \_\_\_\_\_ Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

Please list any allergies or health concerns that your child may have: \_\_\_\_\_

\_\_\_\_\_

Does your child take any medications?  Yes  No If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

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

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

Yes, my child has completed Early Childhood Screening on \_\_\_\_/\_\_\_\_/\_\_\_\_.

If yes, where \_\_\_\_\_

**\*It is your responsibility to provide is with the ECS results from another school district or agency**

No, child has not completed Early Childhood Screening (children receiving scholarship must complete a screening within 90 days of beginning preschool).

Child is scheduled for Early Childhood Screening on \_\_\_\_/\_\_\_\_/\_\_\_\_.

**Parent Signature**

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

Printed name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

## Early Childhood Family Education (ECFE) and School Readiness Parent Questionnaire

**General Information:** Please help us learn about your child and family. Neither you nor your child will be identified in any published report. If you do not wish to participate in the parent questionnaire, it will not prevent you or your child from participating in any program or service. All data provided are protected by state and federal data privacy standards.

If you choose to voluntarily answer the questions, your information will be used by your local school district and the Minnesota Department of Education for program planning and evaluation in line with state and federal data privacy practices. Again, only aggregated information will be published. Thank you for your help in improving public services!

**1. Please indicate whether you are this child's**

Mother       Father       Grandmother       Grandfather  
 Foster Mother       Foster Father       Guardian       Other Relative

**2. Your highest level of school completed. Mark only one.**

Eighth grade       Associate's Degree  
 12th grade       Bachelor's Degree  
 High School Diploma       Master's degree  
 Some college but no degree       Ph. D.

**3. Your Date of Birth (Month/Day/Year) \_\_\_\_\_**

**4. Your current job status, mark only one.**

Employed > 25 hours per week, employed more than 25 hours per week  
 Employed < 25 hours per week, employed less than 25 hours per week  
 Unemployed, seeking employment  
 Unemployed, not seeking employment

**5. What is the race/ethnicity of your child(ren) (circle all that apply)**

White      Black/African/African American      Hispanic or Latino  
Asian      Native Hawaiian or Other Pacific Islander      American Indian/Alaskan Native  
Other, single race      Other, two or more races

**6. What are your primary home languages? (circle all that apply)**

English      Spanish      Hmong      Somali      Vietnamese      Karen      Arabic  
Russian      Mandarin      Laotian      Oromo      Cambodian      Other: \_\_\_\_\_

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

**8. How many people were in your household last year? Circle one.**

2      3      4      5      6      7      8

For School Use Only – SSID Number \_\_\_\_\_



### Financial Aid Application

**Complete this form if you are applying for financial assistance.**

Financial Aid is to ensure children with the greatest needs receive early childhood education. Financial Aid is determined by a combination of risk factors, family size and yearly household gross income. Proof of income must accompany: **Please include a copy of the first page of your 2019-1040 Tax Report for all adults claiming child on their income taxes.**

All information you provide here will be kept confidential and used only for eligibility determination and verification.

Please include any other information you feel is needed in order for the Financial Aid Committee to understand your application. For example, if your most recent Tax Report does not accurately reflect your current income status.

If you have any questions, please call 320-679-6257.

**Please read carefully, then sign and date:**

I certify that all the information provided in the Financial Aid Application Form is true and correct and that all income is reported.

I understand that school district officials ask that the information of this application be verified.

Deliberate misrepresentation of the information may subject me to prosecution under state and federal laws.

\_\_\_\_\_  
Printed Name of Parent or Legal Guardian

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

Child's Name: \_\_\_\_\_ M/ F Birthdate \_\_\_/\_\_\_/\_\_\_

Parent/Guardian's Name: \_\_\_\_\_

**Please check Child Concerns:**

- Child has had little or no preschool experience
- Child was a high-risk pregnancy
- Child's behavior is not appropriate when playing with other children
- Child is a twin, triplet
- Child is in or has been in Foster Care
- Child exposed to drugs before birth – please circle all that apply  
                   alcohol      inhalants      second hand smoke  
                   meth            other: \_\_\_\_\_
- Child has been or is currently exposed to lead

**Please check Child's Health Concerns:**

- Asthma     Cancer     Vision Loss     Tuberculosis     Diabetes
- Heart Disease     Hearing Loss     Corrective Lenses     Hepatitis
- Hearing Aid     Scoliosis     Epilepsy/Seizures     ADD/ADHD
- Sickle Cell Disease     Kidney Problems     Allergies \_\_\_\_\_
- Other: \_\_\_\_\_

**Please check Parent or Primary Caregiver Concerns:**

- Mother was under 18 years old when child was born
- Single parent
- Parent has physical disability (wheelchair, blind, deaf, etc.)
- Parent or guardian has no GED or high school diploma
- Parent mental health problems
- Parent with chemical dependency

**Please check Family Concerns:**

- Living temporarily with other family
- Do not speak English in the home, language spoken in the home: \_\_\_\_\_
- Don't qualify for programs but are in need.
- Family stress: please circle all that apply  
                   unemployment      divorce      death      low income      homeless  
                   chronic illness      other: \_\_\_\_\_
- Family has experienced abuse, neglect, or family violence

List any other information that would help us to understand the child or family's needs:

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