NEW STUDENT CHECKLIST

______Parent(s) proof of identity (picture ID and social security card) copied

______Student's birth certificate and social security card copied

______Insurance card copied

______Immunization record received

______Emergency Card complete (purple)

______ Physical record received – **MUST BY SIGNED and DATED BY A DOCTOR**

______ Application

______ Lead / Asthma Assessment

______ Getting Acquainted

______ Family Demographics & CDBG Client Profile complete

______ Family Contact Information- emergency contact, transportation

_______ Licensed Child Care Center Consent

______ Tuition Payment Contract ____CANI ____Full Pay ____ Scholarship

______Application for free/reduced meals complete

______ CACFP information

Date Received: ________________________________

	Check if Completed	Check if In-complete	Date parent is notified
Child's name			
Physical			
Child's date of birth verified by birth certificate			
Parent's name, address, & telephone number			
Immunizations			
Medication Records			
Information on child's development			
Parent's place of employment, working hours, telephone number, & address			
Name, address, & telephone number of child's dentist & doctor			
Name, address, &telephone number of persons authorized to remove child from the premises			
Name, address, & telephone number of persons who may come for the child in case of illness or emergency			
Date of admission			
Emergency medical authorization for transportation & obtain medical treatment			
Emergency authorization kept in file and with emergency telephone			

MARTIN LUTHER KING MONTESSORI SCHOOL
6001 S. Anthony Blvd. Fort Wayne, IN 46816.
Phone: (260) 423-4333 / Fax: (260) 426-2366

"The US Department of Agriculture and the State of Indiana prohibits discrimination in all USDA programs and activities on the basis of race, color, national origin, sex, age, or disability."

STUDENT SCHOOL APPLICATION

CHILD'S NAME: ____ GENDER_____ DOB: ___/___/___

APPLICATION TYPE: (*Please circle one*) Preschool (age 3 – 5) Summer Only Both

ETHINIC ORIGIN :(*Please circle one*) African-American Caucasian Hispanic Other_________

CHILD'S HOME ADDRESS: ____ ZIP CODE: _________

CHILD RESIDES WITH: (*Please circle one*)

Both Parents___ Mother Only___ Father Only___ Grandparent (s) ___

Foster Parents___Other (*please explain*) ____

PARENT/GAURDIAN NAME: ____RELATIONSHIP:_____________

CHILD'S HOME ADDRESS: ____ ZIP CODE: ___________

HOME PHONE NUMBER: __________________________ CELL/ALTERNATE: ________________________

E-MAIL ADDRESS: ____

EMPLOYER:_______________________________________WORK NUMBER___________________________

IF ATTENDING SCHOOL, *(please list name and phone number of the school)*_____________________________

DOES CHILD HAVE A SIBLING CURRENTLEY ATTENDING MLK? YES ____ NO____

Have any other children in your immediate family attended MLK? YES___ NO___

ARE YOU CURRENTLEY ON ANY PROGRAM TO HELP SUBSIDIZE YOUR CHILDCARE COSTS?

CCDF/CANI______ OTHER_______

IF NO WOULD YOU BE INTERESTED IN THE MLK SCHOLARSHIP/TUITION ASSISTANCE PROGRAM? (*PARTICIPATION BASED ON ELEGIBILITY, FUNDRAISING, AND AVAILIBILTIY OF FUNDS)* YES ______ NO______

Does your child require bus services? Yes ______ No ______

Has your child been diagnosed by a physician as having any special needs that include but are not limited to the following: (*Please circle all that apply*)

Diabetes   Ear Tubes   Eczema   Seizures   Bee Stings   Food Allergies

Pre-Mature Birth   Heart Disease/Murmur   ADHD   Incontinence   Physical Disability

Other *(Please specify)* ____

Is your child currently under the care of a Physician? (*Circle one*)   YES   NO

If you've answered yes to <u>any</u> category, please list all medication, including the name and telephone number of your child's physician:

Name and Address: ____Phone:______________________

List of Medications:____

I understand that this agency does not discriminate against any applicant for admission to this school in regard to gender, race, religion, ethnic origin, ancestry, or physical disability.

I understand that all the information that I have provided on this application is true to the best of my knowledge.

By signing this document, you are confirming your acknowledgement and acceptance of the aforementioned information and understand that MLK reserves the right to refuse services should any information be proven false.

Parent/Guardian Signature: _______________________________________ Date: ___________________

Relationship to child: ____

****

FOR OFFICE USE ONLY

Applicant received in office on: _______________ Application reviewed by: __________________________

Date of which office tried to contact parent: _________________________

Comments:____

____

Date Completed___________________Child's Name____
Last, First, Middle
Parent's Name____Child's Birthdate______________________
Last, First Month, Day, Year
Phone________________________Address____

RETURN FORM TO:
MLK
6001 S. Anthony BLVD
Fort Wayne, IN 46816
Fax 426-2366
Ph: 423-4333

Family: Child lives with (circle one) Mother Father Grandparents Other

PHYSICAL EXAMINATION

	Normal	Abnormal	Comments		Normal	Abnormal	Comments
General Appearance				Nose, Mouth, Pharynx			
Posture, Gait				Teeth			
Speech				Heart			
Head				Lungs			
Skin				Abdomen (include Hernia)			
Eyes External Aspects				Genitalia			
Optic Fundoscopic				Bones, Joints, Muscles			
Ears External Canal				Neurological/Social			

Lead Level __________________Hemoglobin___________Tuberculin Skin Test___________mm (one documented negative required)

Height_______in Weight__________lbs Blood Pressure_____________ Vision _______________ Hearing ________________

Does child have any conditions that might be dangerous to self or others during participation in normal pre-school activities? Yes___No___
If yes, what accommodations are needed to allow the child to attend MLK Montessori School? _____________________________________

CHILD'S MEDICAL HISTORY

Communicable Disease	Month / Year	Condition	Explain if present
Measles		Allergies:	
Rubella (German Measles)			
Chickenpox		Disablng conditions:	
Mumps			
Scarlet Fever		Other:	
Whooping Cough			
Other:			

Family History of Disease: ____

Conditions which could be important in an emergency: Severe Asthma Diabetes Seizures Convulsions Allergies/Reactions
____

Is child taking any medication on a regular basis? YES___NO___ Medication_______________________________________

Has child ever been hospitalized or operated on? YES__ NO___ Explain____

Is child wearing (or supposed to wear) glasses? YES___NO___ Concerns____

Does child have problems with ears/hearing (tubes)? YES___NO___ Concerns____

Does child have special dietary needs? YES___NO___ Explain____

IMMUNIZATION RECORD

HEP B					
Dtap/DTP					
HIB					
Polio					
MMR					
Varicella					
Pneumococcal					

____
Physician's Printed Name

____
Physician's Signature Date

Revised 7/7/13

LEAD

Even if your child has completed a lead test in the past; please consider the following questions. If you answer YES to more than 2 questions, you should have your child screened again.

1. Have you moved into a new home since your child's last lead screening? YES NO Don't Know

2. Does the child live in a home or regularly visit a home or daycare center built before 1978 with peeling paint? YES NO Don't Know

3. Does the child have a brother or sister, housemate or playmate being treated for lead poisoning? YES NO Don't Know

4. Does the child live with an adult whose job or hobby involves exposure to lead? (Includes home repairs, auto repairs, furniture refinishing, firing ranges, casting lead fishing sinkers, and boat repairs) YES NO Don't Know

5. Does the child play near a busy street, an active lead smelter, or other industry likely to release lead? YES NO Don't Know

6. Does the family use imported or glazed ceramics for food preparation, storage or dinnerware? YES NO Don't Know

7. Does the child have medical findings consistent with lead poisoning? (Learning difficulties, behavioral concerns, unable to potty train, nutrition and anemia problems) YES NO Don't Know

ASTHMA

1. In the past 12 months has your child had wheezing in the chest lasting more than one day? YES NO Don't Know

2. Does your child often cough when sleeping? (night or naptime) YES NO Don't Know

3. Does your child have coughing, wheezing or shortness of breath with running or physical activity? YES NO Don't Know

4. Has your child been treated with medication for asthma? YES NO Don't Know

5. Has the doctor or a health care provider ever said your child has asthma? YES NO Don't Know

6. Does your child spend time around someone who smokes? YES NO Don't Know

---

FOLLOW UP BY HEALTH COORDINATOR

Reviewed by R.Schiebel, RN, BSN Date ______________ Notes: ______________________________

Referral to: Registered Dietitian Parkview Asthma Educator Primary Physician None Indicated

Follow Up Resources Given to Family: Nutrition Lead Asthma (Secondhand Smoke)

Getting Acquainted with your Child

Child's Name: ______________________________ Sex: Male______Female: ______ Birth date: ___/___/___

Your Name: ________________________________ Relationship to the child: _______

Sibling (sisters & brothers):

Name: ____________________________________ Age: __________
Name: ____________________________________ Age: __________
Name: ____________________________________ Age: __________

A WORD TO REMEMBER: The answers that you provide in this questionnaire will assist us in getting to know your child better. This will also inform us of any concerns that you may have about your child. The Behavioral Concerns List at the bottom of the page will also assist us in identifying the concerns for your child.

1. Briefly describe your child: ____

   ____

2. What are your child's strengths? _______________________________________

   ____

3. List your child's favorite play materials/activities: _________________________

   ____

4. Does your child have special needs or behavioral concerns? (please list) _______

   ____

The following statements describe potential problems that your child may be experiencing in the home. Read each statement carefully and check the statements that apply.

— Health problems
— Eating problems
— Bowel or bladder problems
— Sleep problems
— Sight/hearing concerns
— Easily distracted
— Very shy
— Speech difficult to understand
— Can be clumsy at times
— Dependant and clingy
— Seldom shows initiative
— Does not always mind well
— Has tantrums or overly aggressive
— Very hyperactive; can't sit still
— Seldom plays with other children

Other: ___________________________

Thank you for completing this questionnaire!!

MLKMS Family Demographics / CDBG Client Profile

Date: _________ Name of Parent/Guardian: ____

1. Home Dwelling :
   - ( ) House
   - ( ) Apartment
   - ( ) Duplex
   - ( ) Mobile home
   - ( ) Townhouse

2. Home Status:
   - ( ) Rent subsidized
   - ( ) Rent unsubsidized
   - ( ) Own home
   - ( ) Homeless

3. How long have you lived at your current address:
   - ( ) under 1 year
   - ( ) 1-4 years
   - ( ) 5-9 years
   - ( ) 10-15 years

4. Are you head of household:
   - ( ) Yes
   - ( ) No

5. If yes, are you
   - ( ) Female
   - ( ) Male

6. Do you receive the following subsidy:
   - ( ) TANF
   - ( ) CANI vouchers
   - ( ) Food stamps

7. Race:
   - ( ) Black
   - ( ) Hispanic
   - ( ) White
   - ( ) Bi-Racial

   Please specify ____________________________
   - ( ) Asian
   - ( ) Other

   Please specify ________________________________

8. What is your age range?
   - ( ) 15-19
   - ( ) 20-25
   - ( ) 26-30
   - ( ) 31-40
   - ( ) 41-50

9. How many children do you have in the below age group?
   - ( ) under 3
   - ( ) 3-10 years
   - ( ) 11-15 years
   - ( ) 16-20

10. How many adults age 19 and older are living in the household? _____

11. Service need while child is in school:
    - ( ) Employment
    - ( ) Training/Education
    - ( ) Both Employment/Training
    - ( ) Protective Services
    - ( ) Other (please explain)

12. What is your marital status?
    - ( ) Single
    - ( ) Married
    - ( ) Separated
    - ( ) Divorced
    - ( ) Widowed

13. What is the highest level of education you have completed?
    - ( ) Grade school (1-8)
    - ( ) High school (9-12)
    - ( ) High school graduate
    - ( ) GED
    - ( ) Training/Journeyman certificate
    - ( ) Associates Degree
    - ( ) Bachelor Degree
    - ( ) Number of years attended college

14. Is there a computer available in the home?
    ( ) Yes ( ) No

15. Do you work on a computer at your place of employment?
    - ( ) Yes
    - ( ) No

16. Does your family have medical insurance?
    - ( ) Yes
    - ( ) No

17. If yes, please indicate coverage
( ) Private
( ) Hoosier Healthwise
( ) Medicaid

18. Primary language spoken in the household: ____________________

19. Means of transportation:
( ) Vehicle
( ) Motorcycle
( ) Public Transit
( ) Other (please specify)

20. Were you a teen parent?
( ) Yes
( ) No

21. As the primary caregiver, are you the biologic parent?
( ) Yes
( ) No

22. If no, please explain: _______________________________

23. Did you child weigh less than 5 lbs at birth?
( ) Yes ( ) No

24. Has your child been diagnosed special needs?
( ) Yes
( ) No

25. Was your child enrolled in First Steps?
( ) Yes
( ) No

26. Household Income:
( ) $5,000 - $10,000
( ) $11,000 - $13,000
( ) $14,000 - $17,000
( ) $18,000 - $20,000
( ) $21,000 - $25,000
( ) $26,000 - $30,000
( ) $31,000 - $35,000
( ) $35,000 - $45,000
( ) $46,000 – higher

27. Source(s) of Income (check all that apply);
( ) Employment
( ) Unemployment
( ) SSI
( ) Disability
( ) Child Support
( ) TANF
( ) Food Stamps

MARTIN LUTHER KING MONTESSORI SCHOOL, INC.
Family Contact Information

SCHOOL YEAR ________
Child's Name ____
Nickname _____________________ Sex _________ Age ____ Birth date ___________
Home Address___________________________ Zip _________ Phone _____________

FAMILY INFORMATION

Adults that the child lives with:
Name _____________________________ Relationship __________________________
Employer's ________________________ Working Hrs. _________________________
Address ___________________________ Phone ______________________________
School/College Attending ______________________ Class Hrs. __________________
Address ____________________________________ Phone _______________________
Highest Level of Education Completed _______________________________________

Name ____________________________ Relationship ___________________________
Employer's _______________________ Working Hrs. __________________________
Address __________________________ Phone _______________________________
School/College Attending ______________________ Class Hrs. __________________
Address ____________________________________ Phone _______________________
Highest Level of Education Completed _______________________________________

Father or mother's name if not residing with the child and is legally responsible for the child:
Name ____________________________________ Relationship __________________
Address __________________________________ Phone _______________________

EMERGENCY CONTACT AND AUTHORIZATION FOR PICK-UP/ DROP-OFF

Give three names of responsible persons who can be called to come for your child in case of illness or other emergencies and also be authorized for pick-up and drop-off if parents cannot be reached:

Name ____________________________________ Relationship __________________
Address __________________________________ Phone _______________________

Name ____________________________________ Relationship __________________
Address __________________________________ Phone _______________________

Name ____________________________________ Relationship __________________
Address __________________________________ Phone _______________________

DENIAL OF PICK-UP

We will NOT release your child to anyone without prior parental verbal and/or written authorization. The following individuals are specifically DENIED permission to pick-up my child:

Name ____
Name ____

DENIAL OF CONTACT/VISITATION

We will not allow anyone to have visitation/contact with your child without parental authorization. The following individuals are specifically denied contact or visitation with my child: **if child's parent is listed we must have court documentation.**

Name ____
Name ____

TRANSPORATION PERMISSION

I, _________________________________, give MLK permission to transport my child between home/daycare center/childcare provider and MLK School and to transport my child for field trips, screening and testing. I understand that my child will be seat belted and that the child staff ratio will be maintained. I understand that there are bus rules and if my child misbehaves he/she can lost his/her bus riding privileges.

PICTURE PERMISSION

I, _________________________________, give MLK permission to use my child's picture in press releases and/or brochures for public relations in regards to Martin Luther King Montessori School.

EDUCATION/HEALTH SCREENING PERMISSION

I, ___________________________________, give Martin Luther King Montessori School consent for my child to participate in all of MLKMS's Health/Development Screenings as listed below:

Speech/Language Screening		Hearing Screening		Vision Screenings
Developmental Screening

NOTE: IF THERE ARE ANY SCREENINGS OR TESTINGS THAT YOU DO NOT WANT YOUR CHILD TO HAVE, PLEASE CIRCLE.

HEALTH EXAMINATION

A health examination, including immunizations, is required before admission to MLK. One health examination is required during your child's attendance. However, immunizations must be kept up to date for re-entry each fall and throughout the year.

MEDICAL NEEDS/ FOOD ALLERGIES

Does your child have any special medical needs or food allergies? If so please state in detail:
____
____

Is your child on any medications? If so, please state: _______________________________

Has this special need(s) been diagnosed by a licensed physician? ____________________

NUTRITION PLAN

Each student is provided daily with breakfast, lunch and an afternoon supplement. Students are encouraged to "try" everything. ALL FOOD ALLERGIES MUST BE DOCUMENTED AND SIGNED BY A LICENSED PHYSICIAN and parents must request and fill out an additional form available in the office.

If your child is not to eat a particular food for religious reasons, please see the office for an additional form.

EMERGENCY MEDICAL AUTHOIZATION POLICIES

I agree, and give consent by my signature that in case of an accident/injury or illness of a serious nature, my child will be given emergency medical care. I understand that I will be contacted immediately or as soon as possible, should I be available at the phone numbers given with the intake agreement. I understand that the doctor, dentist and hospital listed below will be contacted if there is an emergency involved with my child. For minor injuries, I consent for my child to be given first aid or CPR when needed.

____________ ____
Date Parent/Guardian Signature

Hospital Name ______________________________ Phone ______________________
Physician Name _____________________________ Phone ______________________
Dentist Name ______________________________ Phone ______________________

ABSENTEEISM

Excessive absenteeism (over three consecutive absences without a doctor's excuse and/or not contacting the office) may warrant termination of services. (Please see parent handbook).

Date: ____________ Parent Signature:____

MLK Staff: ____

PARENT-TEACHER ORIENTATION/CONFERENCES

Before students begin classes, parent must participate in an orientation with the teacher. All students are put on a 60-day probationary period from the date of intake. If your child changes classes, another orientation with the new teacher must be scheduled. Parent-teacher conferences are scheduled twice a year. However, teachers are always available for ongoing communication and parents are always welcome to come in and observe our program.

Tuition Agreement

Date_____________________

Parent Name:____

Child Name:____

Please initial in the space provided after reading each line.

___ I understand that a non-refundable $45 registration/supply fee is due at the start of each new school year and a $25 summer fieldtrip fee must be paid in **FULL** before starting.

___ I understand that the tuition charged is based on a weekly **FLAT RATE** of $185 per week.

___ I understand that I am responsible for paying $________ per week for my child's tuition, whether my child is in school or not.

___ I understand that I am responsible for paying my tuition and/or swiping EVERY week. Swiping MUST be completed EVERY Friday by 5:45 p.m. If swiping/payment is not received, bus services will be suspended Monday morning until payment/swiping is completed.

___ I understand that any payment/co-payment is due upon receipt of billing. If my account is not paid in full within 14 days, my child will be dropped from the program until payment is made.

___ I understand that tuition is not subject to adjustment due to my child's illness, vacation or other absence from school.

___ I understand that if my check is returned for any reason, a $30.00 charge will be assessed to my account and that cash, money order or cashier's checks are the only forms of payment accepted after a check has been returned.

___ I understand that if I choose to withdraw my child from MLKMS, a written two week notice must be given to the office. If notice is not given, I understand I will be charged for ten school days from the last day of attendance.

_______________________________________ _________________________

Parent Signature Date

_______________________________________ _________________________

Joy Davis Admissions Date