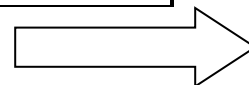




## Voluntary Pre Kindergarten Enrollment Form Program Options 2020–2021

Child's Last Name	Child's First Name	Middle Initial	DOB
Parent Last Name	Parent First Name	Daytime Phone Number	
Street	Apt #	City, State	Zip Code
<b>Schedule Options</b>			
Please select only <b>ONE</b> of the following Program Options			
<input type="checkbox"/> <b>AM Voluntary Pre Kindergarten</b>			
Cost: No Tuition	Monday–Friday	Hours: 8:30am–11:30am	
<input type="checkbox"/> <b>Voluntary Pre Kindergarten + Extended Day</b>			
Cost: \$165 per week + One time fees	Monday– Friday	Hours: 8:30am–4:30pm	
<b>Extended Day Fee and Non–Refundable Deposit Agreement</b>			
A <b>non-refundable</b> fee of \$355 is due when you turn in your registration packet. Please note: <b>All fees are non-refundable.</b> If you choose not to send your child to attend Excell Academy for any reason you will not be refunded.			
Summary of <b>one time</b> fees due with application ( <b>non refundable</b> )	\$25 Registration Fee \$25 Materials Fee \$140 Snack Fee \$165 One weeks tuition		
Summary of <b>Weekly</b> fees	\$165 per week		
Breakfast & Lunch costs are not included in the regular weekly fees. If you would like to be considered for reduced priced or free meals you must complete an Application for Educational Benefits. Forms will be available at the front desk in July 2020.			
The <b>non-refundable</b> deposit of \$355 is required with your registration packet to hold your child's space. The deposit is non-refundable and will be applied to your child's last two weeks of attendance. If you choose not to send your child to Excell Academy for any reason the deposit will not be refunded to you.			
I understand the fees listed above.			
Parent/Guardian Signature: _____		Date: _____	

Turn over to complete back page



## Kindergarten Readiness Program Registration and Financial Agreement Form 2020–2021

Child to be Enrolled:

Child's Name:	Home Phone:
Date of Birth:	Other Siblings at Excell Academy

Mother/Guardian Information

First Name:	Last Name:	
Address:		Apt #
City, State, Zip		
Home Phone:	Occupation:	
Employer:	Work Hours:	
Work Phone:	Cell Phone:	

Father/Guardian Information

First Name:	Last Name:	
Address:		Apt #
City, State, Zip		
Home Phone:	Occupation:	
Employer:	Work Hours:	
Work Phone:	Cell Phone:	

Payments are due in advance of service according to the 2020–2021 payment schedule. All payments are non-refundable. Full payment is due whether or not your child is in attendance (including Holidays and school release days). No refunds are made due to absence. You may request a receipt when making your payment. Multiple payments may be submitted if so desired. You will not receive a weekly or monthly bill or statement for this service. A late fee of \$10 will be assessed for payments received after the due date. A 30-day notice is required prior to dropping out of the Kindergarten Readiness Program. Excell Academy reserves the right to discontinue or limit service due to non-payment. Families with accounts in default incur any costs for collection including legal fees.

I agree to abide by this contract and the financial policies of the Kindergarten Readiness Program.

Parent/Guardian Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_



## Voluntary Pre Kindergarten- Student Enrollment History

Student Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

<b>Race/Federal Ethnicity</b>	
Is your Student Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Race (check all that apply)</b> <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native	<b>Ethnicity (check one)</b> <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> Black, not of Hispanic Origin <input type="checkbox"/> American Indian <input type="checkbox"/> White, not of Hispanic Origin
Does your child have a birth certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was your child born in the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No    If not in the U.S., when did your child move to the U.S.? _____	
Has your child been referred for special education or related services? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is your child currently on an individualized education plan (I.E.P)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>If Yes, what is your students disability? (check all that apply)</b> <input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> Emotional/Behavior Disorders <input type="checkbox"/> Speech/Language Impairments <input type="checkbox"/> Developmental Cognitive Disability <input type="checkbox"/> Other Health Disabilities <input type="checkbox"/> Severely Multiple Impaired <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Physically Impaired <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Deaf- Hard of Hearing <input type="checkbox"/> Specific Learning Disabilities <input type="checkbox"/> Visually Impaired	
Please select any special developmental needs your child has that we should be aware of	
<input type="checkbox"/> Speech Language <input type="checkbox"/> Motor Development <input type="checkbox"/> Self-help skills <input type="checkbox"/> Attention Span	<input type="checkbox"/> Emotional Needs <input type="checkbox"/> Social Development <input type="checkbox"/> Behavioral Problems <input type="checkbox"/> Other
Has your child been enrolled in an English Language Program? (ESL, EL, ELL, etc) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your student have a social worker? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, name and phone number: _____	
Has your student ever been expelled from school? <input type="checkbox"/> No <input type="checkbox"/> Yes    If yes, where? _____	
Early Childhood Screening: If enrolling for Kindergarten, has your student been screened? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, where? _____	
Previous School Attended 2019-2020	
School Name: _____ City/State: _____	
Last Grade Attended: _____ Fax Number: _____	
Previous School Attended 2018-2019	
School Name: _____ City/State: _____	
Last Grade Attended: _____ Fax Number: _____	

**Excell Academy  
Audio/Video Release Form  
2020-2021**

Dear Parents:

Throughout the school year, the media may visit our school to cover special events. Excell Academy may also wish to use your child's photograph, voice or student work for promotional and educational reasons, such as in brochures and newsletters, on the web site, social media or at community fairs. Because of state law, a school must obtain your permission before your child's photograph or voice can be used by the media or by our school.

Please sign and return the bottom part of this page stating whether Excell Academy and the media have permission to use your child's photograph, student work or voice for promotional and educational purposes. Thank you for your cooperation.

.....  
Please fill out below and return it to the school office.

\_\_\_\_\_ ***I give permission for*** \_\_\_\_\_  
*Student's name*  
*to be filmed/photographed/interviewed by the media during school events and for Excell Academy to use my child's photograph/work/voice for promotional and educational purposes.*

\_\_\_\_\_  
*Parent/Guardian signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_ ***I do not give permission for*** \_\_\_\_\_  
*Student's name*  
*to be filmed/photographed/interviewed by the media during school events and for Excell Academy to use my child's photograph/work/voice for promotional and educational purposes.*

\_\_\_\_\_  
*Parent/Guardian signature*

\_\_\_\_\_  
*Date*

EXCELL ACADEMY  
Student Agreement for Using the Internet  
2020-2021

I agree to the following guidelines:

1. I will use the internet as another educational resource.
2. I will not post personal contact information about myself or other people (name, address, telephone, school address).
3. I will not enter any chat rooms on the internet.
4. Email may be used only as a part of a class project. I will use polite and respectful language.
5. I understand inappropriate use will result in but is not limited to cancellation of the privilege of using the internet.

Parents please read and review these expectations with your child before signing this agreement.



Please sign below and return to school

I have read and understand the Student Agreement for using the Internet at Excell Academy and agree to follow it.

Parent/Guardian Signature \_\_\_\_\_

Student Signature \_\_\_\_\_

Date \_\_\_\_\_

**EXCELL ACADEMY  
TRANSPORTATION SERVICES FORM  
2020-2021**

Each family **MUST** have a completed Transportation Form on file to indicate how your child will get to and from school daily. Only one form per family is needed. Please list all student names if there is more than one student.

My Family will NOT need Transportation this year. (Please fill out bottom portion)

**Please be advised that we are not able to provide door to door services for our students.** We will have assigned bus stops in your area. Grades K thru 2<sup>nd</sup> will have bus stops within 1 block of address. Grades 3<sup>rd</sup> thru 8<sup>th</sup> will have bus stops within a 2-3 block radius. If your address is outside of our transportation boundaries we can assign your child to the closest bus stop. If you have any questions, please contact Candace Dunbar at (763) 533-0500 ext.121.

**PLEASE PRINT**

Pick up address: \_\_\_\_\_

Drop off address: \_\_\_\_\_

NOTE: Please indicate if address is a daycare provider.

**PLEASE PRINT CLEARLY!**

Parent Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_ Phone # \_\_\_\_\_  
Other than Parent

**OFFICIAL USE ONLY:**

BUS #	STOP IN:	TIME:
BUS#	STOP OUT:	TIME:

STUDENT NAME:

Reviewed by/date

2020-21 School Year
Student Health Information / Concerns

Student Name: Birth Date Male Female Grade

Parent/Guardian: Phone: Home: Work: Cell:

Dear Parent/Guardian:

Your child's health may affect his or her learning. Health information is important in planning for your child's needs at school. Your input and involvement are important. Please complete this form and return it to school as soon as possible.

HEALTH CONCERNS: Please X and explain if your child has any of the following:

- Yes No
Attention Deficit Hyper-activity Disorder/Attention Deficit Disorder (ADHD/ADD)
Allergies\* (to what? )
Has the allergy been diagnosed by a doctor?
Medication for allergy:
\*Complete allergy action plan if appropriate
Food Intolerance? Describe:
Asthma or other breathing problems: \*Complete asthma action plan if appropriate
Has asthma been diagnosed by a Health Care Provider?
Currently has an inhaler?
Ever hospitalized for asthma? If so, when was last hospitalization?
Other breathing problem (describe):
Diabetes: Type 1\* Type 2 \*Must complete diabetes emergency plan.
Managed by: Diet/Activity Oral meds Insulin injections Insulin Pump
Heart Conditions:
Seizures: Date & type of last seizure:
\*If yes must complete seizure action plan.
Has your child ever had a concussion or head injury? Describe:
Social/emotional/behavioral/mental health concerns:
Is there a current concern that your child has been a target of / instigator of bullying?
Recent surgeries or hospitalizations:
Activity restrictions:
Receives Special Education /IEP/504 Services
Other health concerns:

EMERGENCIES: Does your child have a known health problem that could result in an emergency? Yes\* No

\* Must complete emergency action plan

Please describe:

MEDICATIONS

First, list ALL medications that your child takes:

Now, list ALL medications that your child needs DURING THE SCHOOL DAY. An authorization with parent and health care provider consent is required each school year for all the following listed prescription AND over-the-counter medications. A new consent is needed each school year.

Please complete and sign back of form

**Vision**

- Glasses/contacts prescribed
- Wears glasses/contacts all of the time
- Wears glasses in classroom only
- No vision problem
- Request assistance obtaining glasses

**Hearing**

- Frequent ear infections (more than 3 per year in past year)
- Has ear tube(s)
- Hearing loss  right ear  left ear
- Hearing aid(s)  right ear  left ear
- No hearing problem

**HEALTH INSURANCE:**

My child has health insurance: Yes No

I request assistance with health insurance: Yes No

**HEALTH CARE PROVIDERS:**

Does your child have a doctor or clinic where they usually go for health care? Yes No If yes, please complete the following:

\_\_\_\_\_

<b>Primary Health Provider</b>	<b>Location and Phone</b>
--------------------------------	---------------------------

\_\_\_\_\_

<b>Dental Provider</b>	<b>Location and Phone</b>
------------------------	---------------------------

\_\_\_\_\_

<b>Other</b>	<b>Location and Phone</b>
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Hospital preference \_\_\_\_\_

**I attest to the information provided and give permission for its release for confidential use in meeting my child's health and educational needs in school. I acknowledge that it is my responsibility to inform the school of any changes to the health status of this student including health conditions, needs, and/or allergies.**

Parent/Guardian signature \_\_\_\_\_ Daytime phone \_\_\_\_\_

Print Parent/Guardian name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian e-mail contact: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

The school intends to use the requested information to provide for your child's health and safety needs while at school. You may refuse to supply the requested information—there will be no consequences—it may result in an incomplete health and safety plan for your child. The information you provide will one be shared with those whose jobs require access to this information to ensure your child's safety and school success. (MS section 13.04, Subdivision 2)



# Excell Academy Household Information Survey

2020-2021

Please complete the following:

Name of Student: \_\_\_\_\_

Sex: \_\_\_\_\_ Male \_\_\_\_\_ Female

Birth Date: \_\_\_\_\_

**This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services the student may be eligible to receive.**

1. Is your current address a temporary living arrangement?

\_\_\_\_\_ Yes \_\_\_\_\_ No

2. Is this temporary living arrangement due to loss of housing or economic hardship?

\_\_\_\_\_ Yes \_\_\_\_\_ No

**If you answered YES to the above questions, please complete the rest of this form.  
If you answered NO, you may stop here.**

---

Where is the student presently living? (**Check one**)

\_\_\_\_\_ In a **single** dwelling house or apartment

\_\_\_\_\_ With more than one family in a house or apartment

\_\_\_\_\_ With a family member such as grandparents, aunt, or uncle

\_\_\_\_\_ With a family friend

\_\_\_\_\_ Moving from place to place

\_\_\_\_\_ In a shelter

\_\_\_\_\_ In a motel

\_\_\_\_\_ In a place not designed for ordinary sleeping accommodations such as a car, park or campsite

Name of Parent(s)/Legal Guardian(s): \_\_\_\_\_

Address/Telephone: \_\_\_\_\_

Thank you for your time and cooperation