

For office use only	Start date:	End date:
Days of attendance		



3115 Dickens Avenue. Manhattan, Kansas 66503 Tel. (785) 539-7910
 Website: oakgroveschoolonline.org Email address: director@oakgroveschoolonline.org
 Hours of operation are Monday through Friday, 7:30a.m. to 6:00p.m.

Application for Enrollment

Child's name: _____ Nickname (if any): _____

Circle one: Girl Boy Pronouns: _____

Address: _____

Age of Child: _____ Birth date: _____

Parent/ Guardian Name: _____ E-mail: _____

Telephone: Home: _____ Work: _____ Cell: _____

Parent/ Guardian Name: _____ E-mail: _____

Telephone: Home: _____ Work: _____ Cell: _____

Two Local Emergency/Alternate Contact People (NOT parent/guardian):

1. Name: _____ Phone: _____

Address: _____

2. Name: _____ Phone: _____

Address: _____

1. Enrollment Fee: \$100
2. Please indicate your choice of program (full-time or part-time) below and payment option (monthly or semi-monthly).
 - a. Tuition will be billed in full once per month and will be due on the 1st and the 16th of each month if paid semi-weekly or paid in full on the 1st. If the 1st or 16th falls on a holiday, then the tuition will be due on the next working day. Auto-draft is available.

Full Week	
Tuition Billed Monthly: \$800 _____	
Semi-Monthly: \$400 _____	
Monday/ Wednesday/ Friday	Tuesday/ Thursday
Tuition Billed Monthly: \$590 _____	Tuition Billed Monthly: \$410 _____
Semi-Monthly: \$295 _____	Semi-Monthly: \$210 _____



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Dear Parents,

The information on this survey will help us get to know your child better and help us work effectively with your child. Please feel free to use addition pages or the back of this form if needed. Thank you!

1. What is your child's normal sleep/wake schedule?

2. How does your child act or react when tired?

3. Does your child nap? If yes, does your child has any sleep routines or item to help fall asleep?

4. What is your child's normal eating schedule?

5. What % of the meal does your child normally eat?

6. Does your child have any food allergies or dietary restrictions?

7. Does your child have any strong food likes or dislikes?

8. How does your child act when she/he gets sad, upset, angry and hurt.

9.What sort of discipline do you use at home and how often do you use it?

10.What sort of things does your child like to do most?

11.Do you read to or with your child? If so, how often?

12.Does your child watch TV, play video games, or play on the computer? If yes, what kind and how many hours per day?

13.Does your child play outdoors? If yes, how many hours per day?

14.Are there other children that live with you or spend a lot of time in your house? If so, how old are they and what sort of relationship does your child have with them?

15.Does your child spend regular or significant amount of time in a place other than your home? If so, how much time and how often?

16.Please describe your child's personality.

17.Why did you choose Oak Grove School for your child & how did you hear about us?

18.What is the most important thing we can do for your child?

19.What are some ways you would like to be involved in our school?

20. Have you ever been asked to leave a preschool or childcare center before? If yes, please explain.

21. Please list the name and phone number of the last center/school attended.

22. Does your child receive speech or OT services? If yes, please explain.

23. Do you have any concerns about your child's behavior or social skills? If yes, please explain.



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Photo Permission

I, _____ Parent/Guardian of _____, give consent to Oak Grove School to have my child's photograph and/or video to be taken at school and included in any newspaper/magazine articles, the Oak Grove School website, school archives, and to be posted on the Oak Grove School Facebook page. Photos and videos will not be tagged and will not contain any personal identifiers.

Signature _____ Date _____

Sunscreen Permission

I, _____ Parent/ Guardian of _____, give the teachers and/ or representatives of Oak Grove School permission to apply sunscreen to my child during school hours when necessary.

Signature _____ Date _____

Bug Spray Permission

I, _____ Parent/ Guardian of _____, give the teachers and/ or representatives of Oak Grove School permission to apply bug spray to my child during school hours when necessary.

Signature _____ Date _____



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Authorized Pick Up

I, _____ Parent/ Guardian of _____, give consent to Oak Grove School to allow the following people to pick up my child.

Signature _____ Date _____

Name: _____

Address: _____

Phone Number: _____

Name: _____

Address: _____

Phone Number: _____

Name: _____

Address: _____

Phone Number: _____

Name: _____

Address: _____

Phone Number: _____

Name: _____

Address: _____

Phone Number: _____

Name: _____

Address: _____

Phone Number: _____



**MEDICAL RECORD FOR ALL CHILDREN IN CHILD CARE FACILITIES,
INCLUDING PROVIDER'S OWN CHILDREN**

Parents are to complete the Medical Record and the History of Immunizations for each child in licensed child care facilities. The Medical Record, History of Immunizations, and Child Health Assessment are transferable when the child moves to another licensed child care facility.

Child's First Day in Child Care _____

Name of Child Care Facility _____

Child's Name _____
First Last

Date of Birth _____ Gender _____
MM/DD/YYYY M/F

Parent/Guardian Information

Parent/Guardian Information

Name _____

Name _____

Home Address _____
Street City Zip Code

Home Address _____
Street City Zip Code

Home Phone Number _____

Home Phone Number _____

Employer _____

Employer _____

Work Phone Number _____

Work Phone Number _____

Cell Phone Number _____

Cell Phone Number _____

E-mail Address _____

E-mail Address _____

Best way to contact _____

Best way to contact _____

Persons authorized to pick up the child or to notify in case of emergency (other than the parents):

Name _____
Address _____
Phone Number _____

Name _____
Address _____
Phone Number _____

Child's Physician _____

Phone Number _____

Child's Dentist _____

Phone Number _____

Hospital Preference (for emergencies) _____

Has your physician approved the use of any non-prescription medications for your child such as acetaminophen, cough syrup, or ointments that can be given by the child care provider? No Yes, as follows: _____

Any known allergies or medical conditions of child:

Any major changes at home that might affect your child in care:

Please provide additional information or special instructions that will help the person caring for your child:

Parent/Guardian Signature: _____ Date: _____

History of Immunizations

Required for all children in child care facilities, including the provider's own children. A Kansas Certificate of Immunizations (KCI) may be substituted for this form and attached to the completed Medical Record.

Child's Name: _____ Date of Birth: _____
First Last MM/DD/YYYY

Section I. For a recommended schedule of immunizations, refer to the current schedule published by the Advisory Committee on Immunization Practices (ACIP).

Vaccine	Record the Month, Day and Year that each Dose of Vaccine was Received					
	1 st	2 nd	3 rd	4 th	5 th	6 th
Diphtheria, Tetanus, Pertussis (DTaP)						
Poliomyelitis (IPV/OPV)						
Measles, Mumps, Rubella (MMR)						
Hepatitis B (HepB)						
Varicella (VAR)			Hx of Disease: Physician Signature		Date of Illness:	
Hemophilus Influenzae Type B (Hib)						
Pneumococcal Conjugate (PCV)						
Hepatitis A (HepA)						
Rotavirus **Recommended <8 mo of age; not required						
Influenza(Flu) ** Recommended annually >6 mo of age; not required						

Section II.

Complete this section only if your child is exempted from the law requiring immunizations [K.S.A. 65-508(g)].

The following two options are the **ONLY** exemptions allowed by law. **Please check either (A) or (B) below and complete as required:**

(A) Certification from licensed physician stating that immunization would endanger child's life:

Exempt from following immunizations:

____DTaP/DT ____Tdap/TD ____Pertussis Only ____Polio ____MMR ____HepA ____HepB ____Hib
 ____PCV ____Varicella ____Other

Physician's Signature (required): _____ **Date:** _____

(B) My child is exempt under the law from immunizations. As the Parent or Legal Guardian, I state that I am an adherent of a religious denomination whose teachings are opposed to immunizations.

Section III.

Parent/Guardian Signature: _____ **Date:** _____

Child and Adult Care Food Program ENROLLMENT/INCOME ELIGIBILITY FORM

PART 1 – CHILDREN’S INFORMATION—Required for all children in care.						
Child’s Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care	Circle Meals and Snacks Normally Received		
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast	A.M. Snack	Lunch
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	P.M. Snack	Supper	Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast	A.M. Snack	Lunch
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	P.M. Snack	Supper	Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast	A.M. Snack	Lunch
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	P.M. Snack	Supper	Eve. Snack

INCOME ELIGIBILITY

Please check the boxes that apply to help determine the other parts of this form to complete:

- A family member in our household receives benefits from Food Assistance (FA), Temporary Assistance for Families (TAF), or Food Distribution Program on Indian Reservations (FDPIR). (Please complete Part 2 and 5.)
- One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)
- My child(ren) may qualify for Free/Reduced Price meals based on household income. (Please complete Part 4 and 5.)
- My child(ren) will not qualify for Free/Reduced Price meals. (Please complete Part 5 only.)

PART 2 – HOUSEHOLD MEMBER RECEIVING FA/TAF/FDPIR—	Case Number or Identification Number
Any household member receiving benefits can establish eligibility for all children in the household.	

PART 3 – FOSTER CHILDREN—List the names of any children listed in Part 1 who are foster children.	

PART 4 – TOTAL HOUSEHOLD GROSS INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2.															
List names (First and Last) of everyone in your household, including foster children	Tell us how much and how often. If no income, write "0". Use net income if self-employed.														
	Earnings from Work Before Deductions	Weekly	Every 2 Weeks	2X Month	Monthly	Welfare, Alimony, Child Support	Weekly	Every 2 Weeks	2X Month	Monthly	Retirement, Pensions, Social Security, Other	Weekly	Every 2 Weeks	2X Month	Monthly
1.	\$	<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"/>
2.	\$	<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"/>
3.	\$	<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"/>
4.	\$	<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"/>
5.	\$	<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"/>
6.	\$	<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"/>

PART 5 – SIGNATURE AND CERTIFICATION—REQUIRED		
<p>The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number (SSN) or check the box if no SSN. See <i>Privacy Act Statement on the back of this page.</i></p> <p>If you have listed a case number in Part 2 or are applying on behalf of a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced Price meals, the last four digits of the SSN is not needed.</p> <p>“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 CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws.”</p>		
Signature of Adult X _____	Today’s Date _____	Print Name of Adult Signing _____ Social Security Number (SSN) (last four digits) XXX-XX- _____ <input type="checkbox"/> Check if no SSN
Address _____	City/State/Zip Code _____	Daytime Phone _____

PART 6 – CHILDREN’S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

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 receiving meals during care.

- Ethnicity (check one): Hispanic or Latino Not Hispanic or Latino
- Race (check one or more): American Indian or Alaskan Native Asian Black or African American
 Native Hawaiian or Pacific Islander White

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, the funds your child care center/provider receives may be impacted. 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 Food Assistance (FA), Temporary Assistance for Families (TAF) 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 the meal reimbursement for your child care center/provider. 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.

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, audiotope, 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.

DO NOT FILL OUT - CENTER USE ONLY

- Child(ren) are categorically free based on FA/TAF/FDPIR.
- Homeless, migrant, runaway or head start documentation from school, emergency shelter or agency.
- Foster child(ren) have been identified on this form and qualify for the free category.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

- Child(ren) on this form who are not categorically eligible qualify as follows:

- Check one: Free
 Reduced Price
 Paid

Household Size: _____

Total Income: \$ _____

- Annual Monthly Twice Per Month
 Every Two Weeks Weekly

X _____
Signature of Determining Official

Today’s Date

X _____
Signature of Confirming Official

Today’s Date

NOT VALID WITHOUT SIGNATURE AND DATE.

E/IEF Effective Date: If the institution is using the parent/guardian signature date as the effective date, the form must have been signed by the institution representative within the same month the parent signed the form or the immediately following month. If the institution representative does not evaluate and sign the E/IEF within these guidelines, the institution representative’s signature date must be used as the effective date.