

**Park Rapids School Readiness**  
 301 Huntsinger Avenue  
 Park Rapids, MN 56470  
 218-237-6600

Office Use Only

Registration Date      Enrollment Date

Registration Time      Start Date Age

**Program Available for School Year 2025-2026:  
 Please mark a 1 for first choice and a 2 for second choice**

**3 Year Old School Readiness - \$65/per month, sliding fee and scholarships available**

\_\_ Two Half Days (8-11) Monday & Wednesday **OR** \_\_ Two Half Days (8-11) Tuesday & Thursday

**Child must be 3 as of September 1, 2025 and toilet trained for this class.**

**Return form on or after March 4, 2025**

<u>Legal Student First Name</u>	<u>Legal Middle Name</u>	<u>Legal Last Name</u>	__ 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? <input type="checkbox"/> YES <input type="checkbox"/> 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		Ethnicity
Both Parents	Name		Is this student Hispanic/Latino? ____ No, not Hispanic/Latino ____ Yes, Hispanic/Latino  <p align="center"><b>Race</b></p> 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
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			
			<p align="center"><b>Home Language</b></p> First language learned by pupil _____ Language normally used: By pupil at home _____. By parents at home _____. By student with friends _____.

<b>During the day, the child is usually cared for by: (circle)</b>  Mother _____ Father _____ Grandparent _____ Day Care Provider _____	<p style="text-align: center;"><b>Transportation</b>  <b><u>(There are limited transportation options for the 3 year old program, more info will be provided in the fall)</u></b></p> <p style="text-align: center;">Do you anticipate your child will be:</p> _____ 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	<p style="text-align: center;"><b>School Related Student Support Services</b></p> <p>Check those services that this student receives from the school district</p> _____ 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)
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<b>Day Care Provider Information:</b> Name _____	<p style="text-align: center;"><b>Yes <input type="checkbox"/> No <input type="checkbox"/> I give my permission to 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.</b></p> <p style="text-align: center;"><b>Signature: _____ Date: _____</b></p>
Address _____	
Phone _____	

<b>Conditions which could be important in an Emergency:</b> ___ Mild/Severe Asthma ___ Seizures/Convulsions ___ Medication Allergies (list) _____ _____ Food Allergies _____ _____ Other Allergies _____ Heart Condition _____ Other _____	<b>PREFERRED MEDICAL FACILITY/PERSONNEL TO BE USED IN AN EMERGENCY</b>		
	<b>Primary Health Care Provider</b> Essentia Health – Park Rapids 705 Pleasant Avenue Park Rapids, MN 56470  Doctor's Name _____ <b>If not Essentia Health-Park Rapids, list below</b> Clinic Name _____  Address _____  City _____  Phone _____	<b>Primary Dental Care Provider</b>  Name _____ Address _____ City _____ Phone _____	<b>Hospital Emergency Room</b>  St. Joseph's Area Health Service 600 Pleasant Avenue Park Rapids, MN 56470 218-732-3311 <b>If not St. Joseph's, list below</b> 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.**

<b>#1 Contact Name</b> _____  Physical Address _____  City _____ MN  Work Phone _____ Home Phone _____ Relationship to Child: <input type="checkbox"/> Grandparent <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Brother/Sister <input type="checkbox"/> Step Parent <input type="checkbox"/> Other (list) _____	<b>#2 Contact Name</b> _____  Physical Address _____  City _____ MN  Work Phone _____ Home Phone _____ Relationship to Child: <input type="checkbox"/> Grandparent <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Brother/Sister <input type="checkbox"/> Step Parent <input type="checkbox"/> Other (list) _____
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<b>Is there anyone who is legally restrained from contact with your child?</b> Please provide a copy of the restraining order <b>Name:</b> _____	<b>This form must accompany the child, if he/she is taken to the clinic or hospital for emergency medical care.</b>
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**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 **ISD 309**. Attach additional names as needed or changes occur.

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