La Crescent Montessori & STEM School

Minnesota Public Charter School District 4054
1116 South Oak Street
La Crescent, MN 55947
507-895-4054 (Phone) 507-895-4064 (Fax)

APPLICATION FOR SCHOOL YEAR: _____

Today's Date _____ Received Date _____

Circle the grade for that school year

Pre-K(3) Pre-K(4) K 1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th

Does student reside in La Crescent-Hokah School District? ☐ **yes** ☐ **no**
If no, in which school district does student reside? _____

Full name of child_____

Does child live with primary contact? ☐Yes ☐No

Primary Contact(s) (Please circle all that apply: father, mother; legal guardian)

Name _____

Full Address_____
_____

Primary Phone(___)_____ Description: _____

Primary E-mail _____

Secondary Contact (Please circle all that apply: father, mother; legal guardian or other)

Name & Relationship_____

Full Address_____
_____

Primary Phone(___)_____ Description: _____

Primary E-mail _____

It is the policy of La Crescent Montessori & STEM School (LMSS) not to discriminate on the basis of race, creed, religion, gender, national origin, age, marital status, ethnicity, sexual orientation, disability status, or public assistance status in its educational programs.

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ENROLLMENT FORM

Full name of child_____

Date of Birth _____ Male/Female_____

Age as of September 1st of enrolled year _____

Does student reside in La Crescent-Hokah School District? ☐ **yes** ☐ **no**
If no, in which school district does student reside? _____

Circle the grade for that school year

Pre-K(3) Pre-K(4) K 1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th

Primary Contact(s) (Please circle all that apply: father, mother; legal guardian)

Name _____

Full Address_____
_____

Primary Phone(___)_____ Description: _____
Secondary Phone (___)_____Description: _____
Primary E-mail _____
Secondary Email_____

Secondary Contact (Please circle all that apply: father, mother; legal guardian or other)

Name & Relationship_____

Full Address_____
_____

Primary Phone(___)_____ Description: _____
Secondary Phone (___)_____Description: _____
Primary E-mail _____
Secondary Email_____

PARENTAL CONSENT STATEMENTS

*For each statement, **initial** the line next to the statement if you give consent. If you do not give consent, circle "No" and provide any comments.*

____ I give LMSS and all its staff members permission to administer Syrup of Ipecac to my child after being told to do so by the Poison Control Center.

____ No. Comment:_____

____ I give permission for the LMSS staff to give basic first aid.

____ No. Comment:_____

____ I give permission for my child to participate in walking field trips during operating hours.

____ No. Comment:_____

____ I give this written permission for my child to participate in any of the field trips, tours, and excursions taken in the current school year by LMSS. I understand that all field trips will be supervised by a staff member and/or adult chaperones.

____ No. Comment:_____

____ I give LMSS and all its staff and volunteers permission to arrange for or provide transportation for my child during field trips.

____ No. Comment:_____

____ I give LMSS permission to photograph/videotape my child (during normal activities of the day, during special events and on field trips) for display purposes, yearbook, marketing or special events. Any web photos would be without name or identification.

____ No. Comment:_____

How did you hear about La Crescent Montessori & STEM School?

☐ Radio

☐ Newspaper

☐ Internet

☐ Community Education Publication

☐ Word of Mouth

☐ Other _____

EMERGENCY INFORMATION

MEDICAL MATTERS/EMERGENCY MEDICAL TREATMENT:
I hereby warrant that, to the best of my knowledge, my child is in good health and I assume all responsibility for the health of my child. In the event of an emergency, I hereby give my permission for the school staff to initiate emergency treatment and arrange transportation for my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital doctor. In the event of any emergency, if you are unable to reach me at the above phone numbers in 15 minutes or less, I give the school staff permission to initiate the next level care which may include emergency resources such as Emergency Medical Technician's, Fire and Rescue, police and ambulance. In my absence, I give the following listed people my permission to transport my child and make medical decisions.

Name/Relationship:_____ Daytime Phone:_____

Address_____

Name/Relationship:_____ Daytime Phone:_____

Address_____

Name/Relationship:_____ Daytime Phone:_____

Address_____

Family Doctor:_____ Clinic:_____

Phone:_____

Family Dentist:_____ Clinic:_____

Phone:_____

Family Health Plan Carrier:_____ Policy #:_____

Phone:_____**(Include a copy of insurance card, front and back, and attach to this sheet)**

Are there any allergies to drugs or foods?_____

_____

Does the student take any special medication? (*Please complete a "Medication Order Form")

_____

Are there any health concerns/conditions (ex. asthma, diabetes, vision)?_____

_____

PLEASE COMPLETE THE FOLLOWING INFORMATION IF YOUR CHILD ATTENDS DAYCARE:

Daycare Provider:_____ Phone:_____

Address:_____

The information I have provided is accurate to the best of my knowledge.

_____ _____

Date Signature of Parent/Guardian

STUDENT TRANSPORTATION PLANS

My child will arrive to school by:

- ☐ Walking
- ☐ Biking
- ☐ Bus (include number if known)
- ☐ Parent will drop off
- ☐ Other responsible adult will drop off (include name)_____

_____

Additional Comments:_____

_____

_____

_____

_____

_____

_____

My child will leave school by:

- ☐ Walking
- ☐ Biking
- ☐ Bus (include number if known)
- ☐ Parent will pick up
- ☐ Other responsible adult will pick up (include name)_____

_____

Additional Comments:_____

_____

_____

_____

_____

_____

_____

If school closes early due to bad weather, etc., the above transportation plans remain the same for your child.

Persons other than parents/guardians authorized to call upon or pick up child:

Name:_____ Home Phone:_____ Work Phone:_____

Name:_____ Home Phone:_____ Work Phone:_____

Name:_____ Home Phone:_____ Work Phone:_____

REQUEST FOR STUDENT SOCIAL SECURITY NUMBER

All Minnesota school districts are part of a state-wide computer reporting system which uses the student social security number to record information about your child. This information is, in turn, provided to the Minnesota Department of Education. This Department is required by law to collect and store information about each pupil, each staff member, and each educational program.[1] Therefore, we ask that you, the parent, provide your child's social security number although you are not legally required to do so.

The Department of Education uses this information to determine how much money your school district receives from the state and federal government. This information is also used to judge the quality of the state's educational programs, to improve instruction, to follow trends in student enrollment, and to track student participation in various programs.

Your child's school district will share this information with the Department of Education. The Department of Education will share the information with the Department of Human Services to allocate additional funding and improve instruction. As a parent, you do not have to provide your child's social security number. If you choose not to provide the number, the school district staff might need to submit another type of report to receive money distributed by the state or federal government.

[1] Minnesota Statutes Sections 121.932 and 124.17.

_____

La Crescent Montessori & STEM School
1116 South Oak Street, La Crescent, MN 55947 (507) 895-4054

HEALTH CARE SUMMARY

Child's Name: _____
Birthday: _____
Address: _____
Primary Contact Name: _____
Primary Contact Telephone: _____

To be completed by health care source:
IF PARENTS/GUARDIANS FILL OUT THIS FORM, THEY TAKE FULL RESONSIBILITY TO PROVIDE COMPLETE AND TRUTHFUL INFORMATION.

1. Date of last physical examination: _____
   a. Child's physical examination shall be dated not more than six months prior to nor than three months after admission.
2. How long have you been seeing this child? _____
3. Does this child have any allergies? ☐ Yes ☐ No
   a. If yes, please describe them and indicate special preventions or care needed:

_____
_____

4. Does this child have a history of:
   - ☐ physical handicaps
   - ☐ asthma
   - ☐ diabetes
   - ☐ heart problems
   - ☐ rheumatic fever
   - ☐ seizures
   - ☐ other problems (specify) _____

_____
_____
_____

5. Is this child on any medication? ☐ Yes ☐ No
   If yes, please list: _____
   _____
6. Is a modified diet necessary? Please specify.
   _____
7. Is any condition present that may result in an emergency?

_____
_____

8. What is the status of the child's:
   Vision: _____
   Hearing: _____
   Speech: _____
9. For medical reasons, this child should not receive the following immunizations:

_____

_____ _____
Signature of Licensed Examining Physician (or parent of parent filled out form) Date

_____ _____
Address of clinic/hospital Phone

Full name of child_____

Grade _____Date of birth_____

Are there any allergies to drugs or foods?_____

_____

_____

Does the student take any special medication? (Please complete a "Medication Order Form). _____

_____

Are there any health concerns/conditions (ex. asthma, diabetes, vision)?_____

_____

Primary Contact(s) (Please circle all that apply: father, mother; legal guardian)

Name _____

Cell Phone #1 (_____)_____Cell Phone #2 (___)_____

Secondary Contact (Please circle all that apply: father, mother; legal guardian or other)

Name _____

Cell Phone #1 (_____)_____Cell Phone #2 (___)_____

Insurance Company: _____

Policy Number: _____

Preferred Hospital: _____

Preferred Doctor: _____

****

LMA FIELD TRIP AND YOE BEHAVIOR POLICY:

All students participating in a LMSS Field Trip and/or YOE (Youth Outing and Explorations) event as part of the curriculum at La Crescent Montessori & STEM School will be expected to conduct themselves in an ethical and respectful manner. Inappropriate language, destruction of property, physical aggression, failure to tell staff where you are, disrespect of yourself, others and the environment are some examples of behaviors that will not be tolerated. Any child who exhibits unethical, disruptive or disrespectful behavior *at any time* will be given a warning promptly. If the warning does not result in immediate corrective action by the student, parents/guardians will be notified to come and pick up their student who will be dismissed from the remainder of the LMA field trip/YOE. Please discuss this policy and these expectations with your child so that everyone is aware of this behavior policy.

Date: _____

Student Signature: _____

Parent/Guardian Signature: _____

****

Student Immunization Form

Student Name _____

Birthdate _____ Student Number _____

Minnesota law requires children enrolled in school to be immunized against certain diseases or file a legal medical or conscientious exemption.

FOR SCHOOL USE ONLY
( ) Complete; booster required in _____
( ) In process; 8 mos. expires _____
( ) Medical exemption for _____
( ) Conscientious objection for _____
( ) Parental/guardian consent _____

Parent/Guardian:
You may attach a copy of the child's immunization history to this form OR enter the MONTH, DAY, and YEAR for all vaccines your child received. Enter MED to indicate vaccines that are medically contraindicated including a history of disease, or laboratory evidence of immunity and CO for vaccines that are contrary to parent or guardian's conscientiously held beliefs.

Sign or obtain appropriate signatures on reverse. Complete section 1A or 1B to certify immunization status and section 2A to document medical exemptions (including a history of varicella disease) and 2B to document a conscientious exemption.

Additionally, if a parent or guardian would like to give permission to the school to share their child's immunization record with Minnesota's immunization information system, they may sign section 3 (optional).

For updated copies of your child's vaccination history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-5503 or 800-657-3970.

School Personnel: Be sure to initial and date any new information that you add to this form after the parent/guardian submits it. Also, record combination vaccines (e.g., DTaP+HepB+IPV, Hib+HepB) in each applicable space.

Type of Vaccine DO NOT USE (✓) or (×)	**1st Dose Mo/Day/Yr**	**2nd Dose Mo/Day/Yr**	**3rd Dose Mo/Day/Yr**	**4th Dose Mo/Day/Yr**	**5th Dose Mo/Day/Yr**
Required (The shaded boxes indicate doses that are not routinely given; however, if your child has received them, please write the date in the shaded box.)					
Diphtheria, Tetanus, and Pertussis (DTaP, DTP, DT) • for children age 6 years and younger • final dose on or after age 4 years					5th dose not required if 4rd dose was given on or after the 4th birthday
Tetanus and Diphtheria (Td) • for children age 7 years and older • 3 doses of Td required for children not up to date with DTaP, DTP, or DT series above					
Tetanus, Diphtheria and Pertussis (Tdap) • for children in 7th - 12th grade					
Polio (IPV, OPV) • final dose on or after age 4 years				4th dose not required if 3rd dose was given on or after the 4th birthday	
Measles, Mumps, and Rubella (MMR) • minimum age: on or after 1st birthday					
Hepatitis B (hep B)					
Varicella (chickenpox) • minimum age: on or after 1st birthday • vaccine or disease history required					
Meningococcal (MCV, MPSV) • for children in 7th - 12th grade • booster given at age 16 years					
Recommended					
Human Papillomavirus (HPV)					
Hepatitis A (hep A)					
Influenza (annually for children 6 months and older)					

Additional exemptions:

- **Children 7 years of age and older:** A history of 3 doses of DTaP/DTP/DT/Td/Tdap and 3 doses of polio vaccine meets the minimum requirements of the law.
- **Students in grades 7-12:** A Tdap at age 11 years or later is required for students in grades 7-12. If a child received Tdap at age 7-10 years another dose is not needed at age 11-12 years. However, if it was only a Td, a Tdap dose at age 11-12 years is required.
- **Students 11-15 years of age:** A 3rd dose of hepatitis B vaccine is not required for students who provide documentation of the alternative 2-dose schedule.
- **Students 18 years of age or older:** Do not need polio vaccine.

Student Name _____

Instructions, please complete:
Box 1 to certify the child's immunization status
Box 2 to file an exemption (medical or concientious)
Box 3 to provide consent to share immunization information (optional)

1. Certify Immunization Status. Complete A or B to indicate child's immunization status.

A. Received all required immunizations:

I certify that this student has received all immunizations required by law.

_____
Signature of Parent / Guardian OR Physician / Public Clinic

_____ Date

B. Will complete required immunizations within the next 8 months:

I certify that this student has received at least one dose of vaccine for diphtheria, tetanus, and pertussis (if age-appropriate), polio, hepatitis B, varicella, measles, mumps, and rubella and will complete his/her diphtheria, tetanus, pertussis, hepatitis B, and/or polio vaccine series within the next 8 months.

The dates on which the remaining doses are to be given are:

_____
Signature of Physician / Public Clinic

_____ Date

2. Exemptions to School Immunization Law. Complete A and/or B to indicate type of exemption.

A. Medical exemption:

No student is required to receive an immunization if they have a medical contraindication, history of disease, or laboratory evidence of immunity. For a student to receive a medical exemption, a physician, nurse practitioner, or physician assistant must sign this statement:

I certify the immunization(s) listed below are contraindicated for medical reasons, laboratory evidence of immunity, or that adequate immunity exists due to a history of disease that was laboratory confirmed (for varicella disease see * below). List exempted immunization(s):

_____
Signature of physician/nurse practitioner/physician assistant

_____ Date

*History of varicella disease only. In the case of varicella disease, it was medically diagnosed or adequately described to me by the parent to indicate past varicella infection in _____ (year)

_____
Signature of physician/nurse practitioner/physician assistant (If disease occured before September 2010, a parent can sign.)

B. Conscientious exemption:

No student is required to have an immunization that is contrary to the conscientiously held beliefs of his/her parent or guardian. However, not following vaccine recommendations may endanger the health or life of the student or others they come in contact with. In a disease outbreak schools may exclude children who are not vaccinated in order to protect them and others. To receive an exemption to vaccination, a parent or legal guardian must complete and sign the following statement and have it notarized:

I certify by notarization that it is contrary to my conscientiously held beliefs for my child to receive the following vaccine(s):

_____
Signature of parent or legal guardian

_____ Date

Subscribed and sworn to before me this:
_____ day of _____ 20_____

_____
Signature of notary

3. Parental/Guardian Consent to Share Immunization Information (optional):

Your child's school is asking your permission to share your child's immunization documentation with MIIC, Minnesota's immunization information system, to help better protect students from disease and allow easier access for you to retrieve your child's immunization record. You are not required to sign this consent; it is voluntary. In addition, all the information you provide is legally classified as private data and can only be released to those legally authorized to receive it under Minnesota law.

I agree to allow school personnel to share my student's immunization documentation with Minnesota's immunization information system:

_____
Signature of parent or legal guardian Date

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(507)895-4054 ph (507)895-4064 fax

Home Language Questionaire

The following is to be completed by Parent/Guardian:

STUDENT IDENTIFICATION INFORMATINO		
Student's Full Name		
Date of Birth	Age	Grade Level

STUDENT LANGUAGE INFORMATION

Dear Parents and Guardians:
In order to help your child learn, your child's teachers need to determine which language your child uses most. Please respond to the questions below by checking the appropriate box.

1 Which language did your child learn first?
☐ English ☐ Other (specify): _____

2 Which language is most spoken in your home?
☐ English ☐ Other (specify): _____

3 Which language does your child usually speak?
☐ English ☐ Other (specify): _____

PARENT/GUARDIAN INFORMATION

I hereby verify that the above information is true and correct to the best of my knowledge and belief.

_____
Name (Printed)

_____ _____
Signature- Parent/Guardian Date

The following is to be completed by School District Personnel:

DISTRICT INFORMATION/VERIFICATION INFORMATION

School Name District Number

I hereby verify that the above information is true and accurate to the best of my knowledge and belief.

_____ _____
Name (Printed) Date

_____ _____
Signature - Responsible Authority Title

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La Crescent, MN 55947
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CODE OF CONDUCT

Student Rights:
- Right for a safe place to be
- Right for a Montessori education
- Right for support from parents and teachers

Student Responsibilities:
- Responsible for own behavior; respect of self, of others, and of the environment, at all times
- Responsible for own academics; work that is complete, on time, and of high quality
- Responsible for own attendance; Expectation-100% attendance, on time, every time

Parent Rights:
- Right for a safe place to be
- Right for a Montessori education; information on Montessori education and your child's progress
- Right for support from faculty and staff

Parent Responsibilities:
- Responsible for own behavior; respect of self, of others, and of the environment, at all times in action and language; this includes all students and all staff
- Responsible for own support of your child's academics; prepared home environment, one-on-one support of your child's progress
- Responsible for own assistance of your child's attendance; Expectation-100% attendance, on time, every time

Faculty/Staff Rights:
- Right for a safe place to be
- Right for providing a Montessori education
- Right for support from faculty/staff, parents, and children

Faculty/Staff Responsibilities:
- Responsible for own behavior; respect of self, of others, and of the environment, at all times; this includes all students, families and faculty/staff
- Responsible for own providing of foundation for students at LMSS; including information to families
- Responsible for own attendance; Expectation-100% attendance, on time, every time

Code Violation Consequences

Students:
- Behavioral: removal, detention, suspension, expulsion
- Academic: removal, detention, suspension, expulsion
- Attendance: removal, detention, suspension, expulsion

Parents:
- Behavioral: conference, team meeting, suspension of rights and exclusion from school
- Academics: conference, team meeting, suspension of rights and exclusion from school
- Attendance: conference, team meeting, suspension of rights and exclusion from school

Notes

Team:
The core team consists of student, parents/guardians, student's teacher, school administrator, and staff as determined by the School Board President.

Zero Tolerance:
This is not meant to be a 'zero tolerance' policy. The interpretation of these guidelines and enforcement of them is to be determined by school staff.

Minnesota Fair Dismissal Act:
These guidelines are to be followed in accordance with the Minnesota Fair Dismissal Act.

Minnesota Department of Education

Application for Educational Benefits – School Year 2016-17
School Meals • State and Federally Funded Programs

Step 1 **List all infants, children and students through grade 12 in the household, even if they are not related.** If more space is needed, attach another sheet.

Child's First Name	MI	Child's Last Name	Birthdate	School	Grade	Foster Child? (An agency or court has legal responsibility for the child.) If yes, fill in the circle.	Optional - Is the child Hispanic / Latino? If yes, fill in the circle.	Optional - Racial Identity * Fill in one or more circles for each child. American Indian	Asian	African American	Pacific Islander	White
						○	○	○	○	○	○	○
						○	○	○	○	○	○	○
						○	○	○	○	○	○	○
						○	○	○	○	○	○	○
						○	○	○	○	○	○	○

* The full names of the racial categories are: American Indian or Alaskan Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander and White.

Step 2 **Do any Household Members, including yourself, currently participate in any of the following assistance programs: SNAP, MFIP or FDPIR?** Circle one: **Yes** **No**

Medical Assistance and WIC do not qualify. If **No** > Go to STEP 3. If **Yes** > Write in the. **CASE NUMBER** _____ here: then go to STEP 4.

Step 3 **A. List ALL Adult Household Members including yourself and report all incomes.** (Skip STEP 3 if you answered "yes" to STEP 2 or if all participants are foster children.)

Adults - Full Name For the purpose of school meal benefits, the members of your household are "Anyone who is living with you and shares income and expenses, even if not related." List the full name of each household member not listed in Step 1 and their income(s) in whole dollars. If a person has no income, write in 0 or leave the section blank. This is your certification (promise) of no income to report. Include any college students temporarily away from home.	**Gross Pay from Work** *Do not write in an hourly wage.* Gross pay before deductions (not take-home pay).	Weekly	Bi-Weekly	2x Month	Monthly	**Farm or Self-Employment** Net Income after business expenses. State if annual or monthly.	**Public Assistance, Child Support, Alimony** Payments received.	Weekly	Bi-Weekly	2x Month	Monthly	**All Other Incomes** Pension, retirement, disability, unemployment, Veterans benefits, etc.	Weekly	Bi-Weekly	2x Month	Monthly
	$	○	○	○	○	$	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	$	○	○	○	○	$	○	○	○	○

B. Last four digits of signer's Social Security Number (SSN) or no SSN (required):

X X X – X X TOTAL | | | | | – or ☐ I don't have a Social Security Number.

C. Do any of the children listed in Step 1 receive regular incomes such as SSI or wages?

$	Weekly ○	Bi-Weekly ○	2x Month ○	Monthly ○

Step 4 I certify (promise) that all information on this application is true and correct and all household members and incomes are reported. I understand that this information is given in connection with receipt of federal and state funds and that school officials may verify (check) the information. I understand that if I purposely give false information, my children may lose benefits and I may be prosecuted under applicable federal and state laws. The information I provide may be shared with Minnesota Health Care Programs as allowed by state law, unless I have checked this box: ☐ Do *not* share my information with Minnesota Health Care Programs.

Signature of Adult Household Member (required) _____ Print Name: _____ Date:

Address: _____ City _____ Zip _____ Home Phone: _____ Work Phone: _____

Office Use Only Total Household Size: _____ Total Income: $ _____ per _____ Approved: ☐ Case Number – Free ☐ Foster – Free ☐ Income – Free ☐ Income – Reduced-Price Denied: ☐ Incomplete ☐ Income Too High Signature of Determining Official: _____ Date: _____

Is this form required?

This form must be completed to apply for free or reduced-price school meals, unless:

(1) Your school provides free school meals to all students without applications from households (*Community Eligibility Provision, Provision 2 or Provision 3*) or

(2) You were notified that your children have been directly certified for school meal benefits based on foster care status or participation in the Supplemental Nutrition Assistance Program (SNAP), Minnesota Family Investment Program (MFIP) or Food Distribution Program on Indian Reservations (FDPIR).

Privacy Act Statement / How Information Is Used

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give this information, but if you do not we cannot approve your child for free or reduced-price school meals. 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 are not required when you apply on behalf of a foster child, or you provide an MFIP, SNAP or FDPIR assistance number, or you indicate that the adult household member signing the application does not have a Social Security number.

Only authorized officials will have access to the information that you provide on this form. We will use your information to determine if your child qualifies for free school meals, and for administration and enforcement of the school meal programs. We *may* share your information with other education, health, and nutrition programs to help them evaluate, fund or determine benefits for their programs, with auditors for program reviews, and with law enforcement officials to help them look into violations of program rules. We require written consent from you before sharing information for other purposes.

Please provide the requested information about children's race and ethnic identity. This information is not required and does not affect approval for program benefits. We use the percentages of participants in each racial/ethnic category to check that our program is operated in a nondiscriminatory manner in compliance with federal civil rights laws

At public school districts, each student's school meal status also is recorded on a statewide computer system used to report student data to the Minnesota Department of Education (MDE) as required by state law. MDE uses this information to: (1) Administer state and federal programs, (2) Calculate compensatory revenue for public schools, and (3) Judge the quality of the state's educational program.

Information provided on this form may be shared with Minnesota Health Care Programs, unless the person completing this form has checked the box in Step 4 to not share information for that purpose.

Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA *Program Discrimination Complaint Form* (AD-3027) found online at: *http://www.ascr.usda.gov/complaint_filing_cust.html*, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail to 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 to (202) 690-7442; or (3) email to *program.intake@usda.gov*. This institution is an equal opportunity provider.

Office Use Only: Verification

Date Verification Sent: _____ Response Due: _____ 2nd Notice: _____

Result: ☐ No Change ☐ Free to Reduced-Price ☐ Free to Paid ☐ Reduced-Price to Free ☐ Reduced-Price to Paid

Reason for Change: ☐ Income ☐ Case number not verified ☐ Foster not verified ☐ Refused Cooperation ☐ Other: _____

Signature of Confirming Official: _____ Date: _____ Signature of Verifying Official: _____ Date: _____

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RECORDS REQUEST

REQUEST FOR INFORMATION FOR REGISTRATION OF NEWLY ENROLLED STUDENT

Date:_____

To: Previous School Attended
Name of Previous School:_____
Fax Number:_____
Street Address:_____
_____

Regarding this Student
Name of Student:_____
Birthdate:_____ Grade:_____

Please send this student's official school record including courses, grades, identifying information, attendance record, standardized test results, and teacher evaluations. Also please send health records, special education records including related services, and discipline records.

Send this information to:
La Crescent Montessori & STEM School
1116 South Oak Street
La Crescent, MN 55947

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CONSENT FOR RELEASE OF INFORMATION

I hereby authorize release of these official school records.

_____ _____
(Date) (Signature of Parent or Guardian)

Special education services available for students who qualify.