

ECFE Registration

Date Received: _____

Complete a separate registration form for each child registered for an ECFE class or Sibling Care.

Payment, and a copy of immunization record, and health forms (if needed) must be submitted at the time of registration.

Child Attending Class

First Name _____ Middle Name _____

Last Name _____ Male Female

Birth Date _____

Address _____

City _____ Zip _____

1. Parent/Guardian First Name _____ Last Name _____

Address: _____

Birth Date _____ Cell Phone _____

E-mail Address _____

Male Female Relationship to child _____

2. Parent/Guardian First Name _____ Last Name _____

Address: _____

Birth Date _____ Cell Phone _____

E-mail Address _____

Male Female Relationship to child _____

Adult attending class with child: _____

How did you learn about our program? _____

Are you interested in Volunteering? Yes No

Do you need Interpreter Assistance? Yes No

Does your child have any health or physical concerns that we need to be aware of? _____

Does your child have any food allergies? Yes No

If Yes, please list _____

Is your child receiving, or has your child in the past received, any Special

Education services? Yes No

If yes, please list staff who have worked with your child: _____

The questions below are optional, however answers are strongly encouraged. The information from this data will help the Minnesota Department of Education. Data will be handled and protected by state and federal education data privacy laws.

Please indicate whether you are the child's

Mother Father Grandmother Grandfather

Foster Mother Foster Father Guardian Other Relative

Your highest level of school completed (Mark only one)

Eighth grade 12th grade HS Diploma Some college-no degree

Associate's Degree Bachelor's Degree Master's Degree Ph.D

Number of people in household (circle one): 2 3 4 5 6 7 8

What is your current job status?

Employed more than 25 hours per week

Employed less than 25 hours per week

Unemployed, seeking employment

Unemployed, not seeking employment

What was your household's total yearly income, before taxes last year?

\$ _____

What is the primary language spoken by the child? (circle all that apply)

English Spanish Hmong Somali Vietnamese Karen Arabic

Russian Mandarin Laotian Oromo Cambodian Other: _____

What is the race/ethnicity of your child(ren)? (circle all that apply)

White Black/African/African American Hispanic or Latino Asian

Native Hawaiian or Other Pacific Islander American Indian/Alaskan Native

Other, single race Other, two or more races

Required: Behavior & Photo Agreements

Please check the boxes below to confirm that you agree to the terms listed on page 10.

I have read and agree to the terms of the Behavior Plan Agreement.

I have read and agree to the terms of the Photo Agreement.

1-8 Week Classes

Option 1 Class number _____ Fee _____

Option 2 Class number _____ Fee _____

Option 3 Class number _____ Fee _____

Do you need sibling care? Yes No

(If offered for your class choice)

Sibling Care Fee _____ Class Fee _____

Total Fee _____

14-30 Week Classes

Option 1 Class number _____ Fee _____

Option 2 Class number _____ Fee _____

Option 3 Class number _____ Fee _____

Do you need sibling care? Yes No

(If offered for your class choice)

Sibling Care Fee _____ Class Fee _____

Total Fee _____

Sibling Care Information

Immunization information must be submitted with registration for all children attending sibling care

Name _____ Birth Date _____

Name _____ Birth Date _____

Any special needs or allergies? _____

Payment is due at time of registration

Cash, Check, Discover, MasterCard, VISA, or electronic bank payments are accepted.

Make checks payable to ISD 279.

Credit Card Payment Information

Discover MasterCard VISA

Charge will appear as Osseo Area Schools

Card # _____

Expiration Date _____ 3-Digit Code _____

Name on card _____

Billing address if different _____

Office Use: Date _____ Cash _____

Check # _____ Amount _____