Student Name_____

Date Application Received _____

Application Received by _____

FCSD #24
Little Wranglers Early Learning Center 2024-25

Application Checklist: Please return this cover sheet with the required forms.
Applications will be accepted beginning on 3/1.
Completed items 1-4 are required before applications will be considered:

1. _____ **Completed Application**: If mailing, send to
   Administration Office
   c/o Little Wranglers Early Learning Center Application
   404 Wrangler Way
   Shoshoni, WY 82649

   _____ Signed Tuition Rate/Contract
   _____ Enrollment form
   _____ Authorization for Medical Treatment
   _____ Recognition of Understanding
   _____ Permission to Obtain/Release Information
   _____ Permission to Screen
   _____ Student Health History

2. _____ **Birth Certificate**
3. _____ **Immunization Record**
4. _____ **Deposit paid**

4 yr old preschool- No Deposit; 4 yr old full time- $50; 3 yr old Part Time-$50; 3 yr old Full time $100
*Checks made out to FCSD #24, with a memo of Little Wranglers/Shoshoni Staff May Include a Deposit OR Signed Payroll Deduction

5. Optional
   _____ (Free/Reduced Lunch Form) Highly Recommended
   _____ DFS application for reimbursement if requested

****CDS Screening REQUIRED for final acceptance ****
_____ CDS screening:

- April 23rd: 9-11:00 am Shoshoni Screening, come in and see the classroom and complete screening (call to schedule an appointment at the elementary school office 307-876-2563).
- August Screenings will be done in Shoshoni at the beginning of the year.
- You may call CDS at 856-4337 to schedule a Riverton screening appointment

Recommended: Every child needs to do a screening EACH year! If you have a prior screening, please include a copy.

FCSD #24 Little Wranglers Early Learning Center

Tuition Rates/Contract for 2024-25
Deposits Due:
4 yr old preschool only- $0; 4 yr old full time- $50; 3 yr old Part Time-$50; 3 yr old Full time $100

***Part-time rates will be totaled into a monthly tuition**		**Age 4 by 9/15**	**Age 3 by 9/15**
Preschool Only	Mon-Thurs 8-11	Free	$180/month
Add Friday to Prek only	Mon-Thurs 8-11 Fri 8:15-1:30	$65/month	$215/month
School Day	Mon-Thurs 8-3:30 Fri 8:15-1:30	$280/month	$425/month
Part-time full day	8-3:30 less than full week	$25/day	$25/day
Part-time half day	Mon-Thurs 8-11:00 Add 11-3:30 less than full week	$15/half day	$15/half day
Drop in Care: not contracted	If available only	$30/day pre-pay $20/Friday	$30/day pre-pay $20/Friday

**Applications are available to apply for DFS tuition reimbursement for afternoon care. Please request an application or apply online if interested.

Fremont County School District #24 Tuition Agreement

I, _____, agree that Fremont County School District #24
(Parent)

will care for _____
(child's name)

The schedule will be _____ beginning at start of school year or other _____.

*****The tuition rate will be _____ due each month.**

_____ _____

Parent Signature/Date Director Signature/Date

*The Shoshoni Rec Department van runs Mon-Thurs at 11:00, transporting students
**Students ages 4 & 5 may ride the school bus to and from school
Please indicate your child's intended transportation:
Bus (4-5 year olds) _____ Parent pick up _____ Shoshoni Rec Van _____

Please select the most appropriate answer, it helps us plan accordingly.
My child is toilet trained:
Completely (seldom or never has accidents)_____
Partially (has accidents 1-4 times per week) _____
Needs support (has accidents more than 5 times per week) _____

FREMONT COUNTY SCHOOL DISTRICT #24
STUDENT INFORMATION SHEET
2024/2025

* PRINT STUDENT'S FULL LEGAL NAME

FIRST	MIDDLE	LAST

Grade_____ DOB_____ **NICKNAME** _____
(what student goes by)

Home Phone #_____

Physical Address_____

Mailing Address If Different_____

PARENT/GUARDIAN EMAIL ADDRESSES _____

_____

TEXT MESSAGE AND EMAILS WILL BE OUR PRIMARY NOTIFICATION METHOD

Parent/Guardian first & last name	Home Phone	Work Phone	Cell Phone	Child lives with? Y/N

Emergency contact name(s)	Relationship	Phone#'s	

Special Services	Gender	Hispanic/ Latino?	Race* (circle all that apply)	Ethnicity** (circle one)
Y N	M F	Y N	AI/AI A B/AA NH/PI W	A B H I W

*__AI/AI__=American Indian or Alaska Native; __A__=Asian; __B/AA__=Black or African American; __NH/PI__=Native Hawaiian or Pacific Islander;
**__A__=Asian or Pacific Islander; __B__=Black (Not Hispanic); __H__=Hispanic; __I__=American Indian or Alaskan Native; __W__=White

Primary language spoken in the home English Spanish Other* *Please identify:_____

Primary language spoken by the student?_____

What language/languages are spoken or understood by the student? _____

What is the language your child first learned or spoke? _____

Is student homeless? **Yes** or **No** Is the student in Foster care? **Yes** or **No**

Is one, or both, of the student's parents or guardian on Active Duty, in the National Guard, or in the Reserve components of the United States military services?

a) Not Military Connected b) Active Duty c) National Guard or Reserve

OTHER CHILDREN IN THE HOME	Gender	Age	Date of Birth
	M F		
	M F		
	M F		
	M F		
	M F		
	M F		

In case of serious accident/injury, all attempts will be made to reach the named parent/guardian. In the event that parents, emergency contacts, or physicians cannot be reached, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment for the health of my child. I will not hold the school district financially responsible for my child's emergency care and/or transportation.

Parent/Guardian Signature _____ Date _____

Permission to Obtain & Release Information

Dear Parent:

In order to obtain and release information regarding your child, _____, please complete and return this form. If you have any questions, my contact information is provided below.

Name & Title of Contact Person	Address
Brittany Jones, Case Manager	**Mailing: PO Box 593 Lander WY 82520** **Physical: 1202 E. Jackson, Riverton WY 82501**
Phone	**Email**
(307-856-4337	**bjones@cdsic.org**

I, the undersigned, hereby request and authorize:	
School District or Public Agency:	**Child Development Services**
Address:	**1202 E. Jackson, Riverton WY 82501**
School District or Public Agency Contact Person:	**Brittany Jones**

To release to or obtain to/from:	
Agency:	**Fremont County School District No. 24**
Address:	**404 Wrangler Way, Shoshoni, WY 82443**
Agency Contact Person:	**Heidi Christensen, Early Learning Center, Director**
Telephone/Fax:	**Ph: 307-876-2563 Fax: 307-876-2542**

Information Provided for:	
Name of Child:	**Date of Birth:**

Information Requested:
☐Official child academic/administrative records (identifying information, grade level completed, grades, class rank, attendance records, and group aptitude and achievement assessment results)
☐Medical and/or related health records, including:
☐Special Education confidential file (Evaluation, Eligibility & IEPs)
☐Participation, development or implementation of the IEP and exchange of applicable agency documents.
☐Other (specify):

Purpose of Disclosure
Educational Purposes, Early Intervention

*** This permission is valid for one year from the date signed. A copy of this form is as effective as the original.**

I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release information. I recognize that health records, once received by the school district or public agency, may not be protected by the HIPPA Privacy Act and may become education records protected by the Family Educational Rights and Privacy Act (FERPA). I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

Signature	Relationship	Date

Child Development Services of Fremont County
1202 E. Jackson Ave. or 1205 E. Lincoln Ave., Riverton, Wyoming 82501 ♥ (307) 856-4337
100 Pushroot Court Lander, WY 82520 ♥ (307) 332-5508

Date:_____

ALL QUESTIONS MUST BE ANSWERED

Child's Name:_____ Sex:_____ Title XIX:_____
Date of Birth: _____ Are you the child's parent/legal guardian: ☐Yes ☐No
Parent/Guardian 1 Name:_____ Phone: _____
Parent/Guardian 2 Name:_____ Phone: _____
Race:☐ White ☐ African American ☐American Indian/Alaskan Native ☐Asian ☐Hawaiian/Pacific Islander
Ethnicity: ☐Hispanic ☐Non-Hispanic
Enrolled Tribal Member: ☐Yes ☐No Which Tribe_____
Child's Physical Address: _____ City:_____
Child's Mailing Address:_____ City:_____
Preferred Method of Contact: ☐Email ☐Call ☐Text
Email address:_____
Physician:_____ Premature: ☐Yes ☐No Weeks Gestation: _____
Any health or medical diagnosis?_____
Developmental Concerns: ☐Autism ☐ADHD ☐Speech/Language ☐Behavior
☐Other:_____
Have you been told your child has a Developmental Delay? ☐Yes ☐No By Whom:_____
Does your child have an IFSP or IEP plan in place? ☐Yes ☐No Where:_____

PARENT PERMISSION FOR SCREENING

By signing this form, I give permission for my child to participate in a developmental screening. This screening is sponsored by Fremont County School Districts and shall include instruments designed to measure vision, hearing, and developmental skills. All information gathered from this screening shall remain confidential. All hearing and vision screenings will be entered into the Wyoming Early Hearing Detection and Intervention website. I understand that by giving this permission, my child will be screened only, and no formal evaluation and/or programming shall occur without my written permission.

Parent/Guardian signature _____ **Date** _____

FOR OFFICE USE ONLY

SCREEN DATE _____ **SCREENING LOCATION**_____

Screening Results: ☐ Pass ☐ Refer ☐Rescreen
Communication: ☐P ☐R ☐Re
Articulation☐ Language☐
Fine Motor: ☐P ☐R ☐Re
Gross Motor: ☐P ☐R ☐Re
Cognition: ☐P ☐R ☐Re
Adaptive: ☐P ☐R ☐Re
Social/Emotional: ☐P ☐R ☐Re

Parents Notified? ☐ YES ☐ NO

Hearing: ☐Pass ☐Rescreen
EHDI: ☐ YES ☐ NO
Vision: ☐ Pass ☐ Rescreen
EHDI: ☐ YES ☐ NO

Screener Name _____ **Signature** _____
Screener's Comments:

Shoshoni Schools Student Health History

Please fill out completely

Name_____ Birthdate_____ Grade_____ ☐ M ☐ F

Physician Name _____ Phone Number _____ Last well child check up_____

Immunizations Current? ☐ Yes ☐ No If no, please explain _____

List ALL prescription and over-the-counter medications taken by student regularly and as needed (add additional sheet if necessary):

Name of medication	Strength of medication	What time is medication taken?	What is medication used for?

ADD/ADHD ☐ Yes ☐ No
Comments_____

Allergies ☐ Yes ☐ No
List all (example: medications, animals, food, pollen):_____
Has the allergy required emergency action in the past? ☐ Yes ☐ No
Comments_____
Special dietary needs through the school kitchen require orders from a physician

Asthma ☐ Yes ☐ No
Triggered by _____ Date diagnosed _____
Physician _____ Last check up _____

Bee Sting Allergy ☐ Yes ☐ No
Describe reaction _____
Difficulty breathing ☐ Yes ☐ No Need emergency medication ☐ Yes ☐ No

Bone or Joint Condition ☐ Yes ☐ No
Describe (including any physical restrictions) _____
_____
History of broken bones? ☐ Yes ☐ No If yes, describe _____

Cerebral Palsy ☐ Yes ☐ No
Describe any physical limitations _____
Child requires: ☐ wheelchair ☐ walker ☐ neither
Physician _____ Last check up _____

Diabetes ☐ Yes ☐ No
Type I or Type II _____ Date diagnosed _____ Takes insulin ☐ Yes ☐ No
If yes, describe _____
Physician _____ Last check up _____

Student's symptoms of high BG _____
Student's symptoms of low BG _____

Epilepsy/Seizures ☐ Yes ☐ No
Describe seizures _____Date of last seizure _____
Physician name _____ Last check up _____

Heart condition ☐ Yes ☐ No
Describe _____
Describe any physical restrictions_____
Cardiologist? _____ Last check up _____

High or Low Blood Pressure ☐ Yes ☐ No
☐ High ☐ Low Date diagnosed _____ Symptoms _____
Physician name _____ Last check up _____

Spina Bifida ☐ Yes ☐ No
Child requires: ☐ wheelchair ☐ diaper change ☐ catheterization
☐ Other _____

Scoliosis ☐ Yes ☐ No
Date diagnosed _____ Physician _____ Last check up _____

Describe treatment and any physical limitation_____

PLEASE SEE REVERSE SIDE FOR FURTHER INFORMATION

Head Injury/concussion □ *Yes* □ *No* Loss of consciousness? ☐ Yes ☐ No If yes, describe _____

Diagnosed by doctor _____ Date _____

Describe any physical limitations_____

Eyes: ☐ Glasses ☐ Contacts ☐ Reading ☐ Difficulty Seeing ☐ Crossed ☐ Lazy eye ☐ Distance Last vision exam: _____
Physician name _____ Comments: _____

Ears: ☐ Tubes ☐ Hearing difficulty ☐ Hearing aid: ☐ right ☐ left ☐ wear at school Last exam: _____
Physician name _____ Comments::_____

Dental: _____Dentist Name: _____ Last exam: _____

☐ Nosebleeds _____ ☐ Eating _____ ☐ Sleeping _____ ☐ Bladder _____ ☐ Bedwetting _____

☐ Bowel _____ ☐ Neurological _____ ☐ Headaches _____

☐ Lungs _____ ☐ Phobias _____ ☐ Skin _____ ☐ Menstruation _____

☐ Blood disorder _____ ☐ Birth defects _____

Surgeries:_____

List any condition that prevents P.E. participation (must have physician orders):_____

Special Education needs/history: _____

Any condition not listed above _____

Do you need to speak with the school nurse? ☐ Yes ☐ No If yes, best contact number/relationship to student/time

_____

Parent Printed Name _____

Parent Signature _____ Date _____

IMMUNIZATIONS:

Please read and complete the following to grant the school nurse permission to access student's immunization records.

School Nurse WyIR Access Agreement

To ensure the Wyoming Department of Health is aligning with the Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule, Wyoming School Nurses must obtain parent/guardian agreement before accessing a student's immunization record within the Wyoming Immunization Registry (WyIR).

No student record shall be accessed in the WyIR by a School Nurse without parent/guardian agreement.

I, _____, am the parent/guardian of _____ with date of birth _____ and agree that my student's School Nurse can access my student's immunization record in the Wyoming Immunization Registry.

This consent is valid while my student attends Fremont County School District #24, unless revoked by me in writing.

_____ _____

Parent/Guardian Signature Date

This page must be COMPLETED BEFORE INTERNET ACCESS WILL BE ALLOWED.

Parents: Read **AND INITIAL** each of the following releases, then **sign, date and return** to the school.

Publication of personal information on the Internet and/or media events I have read and understand the Laptop Acceptable Use Technology Policy. I release the district from any liability resulting from or connected with the publication of my child's work, first and last name, or photograph. (School Facebook account, news articles, Dojo, and school publications) **If you do NOT wish to have these published, please notify the school principal in writing.** I understand the Wyoming Department of Education or Shoshoni Schools may use my student's photo and/or audio and video recordings to promote a healthy image of our students, schools, and practices.	*INITIAL* *INITIAL*
Parent/Guardian Insurance Waiver I understand that the district does not provide any type of health or accident insurance for injuries incurred by my child at school or at a school activity. ***I have health/accident insurance to provide for care of my child in the event of an accident. Proof of insurance will be required before students may participate in extracurricular activities.*** For voluntary student insurance at your cost, you can enroll here: www.studentinsurance-kk.com	*INITIAL*
Sensory Integration I give permission for my child to use sensory integration techniques on an as-needed basis including but not limited to weighted lap pads, fidgets, noise-canceling headphones, wiggle seats, and bouncy bands during class to meet student needs and improve participation, attention, and in-seat classroom performance.	*INITIAL*
Permission to Seek Emergency Medical Treatment I hereby authorize Fremont County School District #24 and its faculty members in charge of my child (named below) to obtain all necessary medical care in the event that I cannot be reached to authorize it myself. I hereby authorize any licensed physician and/or medical personnel to render necessary medical treatment to my child.	*INITIAL*
Dispensing Medications at School Medication Authorization Form must be completed prior to students receiving medication while at school. For a copy of the form, please see the school nurse.	*INITIAL*
Handbook Requirements I have read and discussed the student handbook with my child. S/he and I agree to abide by the policies and procedures in this book. Handbooks can also be found on our webpage.	*INITIAL*

Parents ***must initial each box above and sign below*** and students **sign** to acknowledge that you have read and understand each of the releases and/or warnings.

Parent Signature _____ Date _____

Student Name _____**GRADE** _____