



Geri Allcorn- Director/Owner
913-338-4282
www.pioneerpreschool.com
11100 College Boulevard
Overland Park, KS 66210

The time for enrollment for the 2026-2027 school year has arrived. To give our currently enrolled families priority we are opening enrollment now through February 5, 2026. Enrollment forms will be accepted in the order in which they are received. **Please make sure to indicate your preference of class days and time as these will be honored as space allows.** After February 5 enrollment will be open to the general public.

To enroll your child for next year, please submit the attached enrollment forms and your non-refundable \$125.00 registration fee. If your child currently attends Pioneer Preschool LLC, all Kansas required health forms are on file with us. Please contact the office if you have questions about enrollment.

3 YEAR OLD PRESCHOOL CLASSES

Monday and Wednesday **OR** Tuesday and Thursday AM classes- 9:00-11:30 AM \$190.00 per month

KINDERGARTEN READINESS CLASSES (4 AND 5 YEAR OLD CHILDREN)

Monday, Wednesday and Friday AM class- 9:00-11:30 \$215.00 per month

Tuesday, Wednesday and Thursday PM Class- 12:15-2:45 \$215.00 per month

TRANSITIONAL KINDERGARTEN CLASSES (5 YEAR OLD CHILDREN)

Monday, Tuesday, Thursday and Friday AM class- 9:00-11:30 \$260.00 per month

Extended day

We offer an extended day session in the morning or afternoon for an additional fee of \$80.00 per month for one extended day per week. Children can enroll in more than one extended day per week if space is available. Children enrolled in a morning preschool class will extend their day until 2:30 PM. Morning extended day classes will begin at 9:30 AM for those enrolled in an afternoon preschool class. Please mark your preference on the enrollment form if you are interested in enrolling your child in the extended day(s) session.

Fees and Tuition

A non-refundable registration fee of \$125.00 must be submitted with your enrollment forms. One month's tuition is due by July 24, 2026. You may include this amount with your enrollment forms, or an email reminder will be sent at a later date. All enrollment forms and payments can be returned in person or mailed to Pioneer Preschool LLC.

We are looking forward to another great school year.

For Office Use Only

Date application received _____

Date registration fee paid _____

Check # _____ Cash _____

Teacher _____ Class _____



**PIONEER
PRESCHOOL, LLC**

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PLEASE PRINT:

Name: _____ Circle One: Male Female
First Middle Last

Preferred Name: _____ Birthday: ____/____/____

Home Address: _____ City: _____ State: _____ Zip: _____

Mother's Name: _____ Mother's cell phone number: _____

Mother's address (if different): _____

Mother's Email address: _____

Mother's place of employment: _____ Mother's business phone number: _____

Father's Name: _____ Father's cell phone number: _____

Father's address (if different): _____

Father's Email address: _____

Father's place of employment: _____ Father's business phone number: _____

Child lives with: Both Parents: _____ Mother: _____ Father: _____ Other: _____

Other children living in the home and ages: _____

Previous group experiences that your child has had (Sunday school, preschool, sports activities etc.): _____

School district your child will be attending: _____

Is your child: Right handed: _____ Left handed: _____

Does your child speak any other language besides English? Yes: _____ No: _____

If yes, please give details: _____

Does your child have allergies? _____ If yes, please explain: _____

Please explain any pertinent medical information that we should be aware of: (asthma, speech problems, vision problems, premature birth, toilet problems, etc.)

Permission to give First Aid: (Band-aids, Bactine, Ice Packs etc.) _____ (Please Initial)

Please list any fears, dislikes, interests etc. that your child may have: _____

AUTHORIZATIONS:

Emergency contacts

Person(s) other than parent that we can contact in case of illness/emergency if parents are unavailable.

Two emergency contacts are required.

Name/Relationship: _____ Cell Number: _____

Name/Relationship: _____ Cell Number: _____

Person(s) authorized to pick up your child from school

(child will only be released to those listed with proper ID)

Name/Relationship: _____ Cell Number: _____

Name/Relationship: _____ Cell Number: _____

Name/Relationship: _____ Cell Number: _____

Class preference: Please indicate your 1st and 2nd choices

Kindergarten Readiness Program

4 and 5 year old children

_____ M/W/F AM

_____ T/W/TH PM

3 Year old preschool

3 years old children

_____ M/W AM

_____ T/TH AM

Transitional Kindergarten

5 year old children

_____ M/T/TH/F AM

_____ Extended Day(s) _____, _____, _____ list day(s)

Please read, initial and sign:

_____ I understand that the non refundable registration fee of \$125.00 is due with this application and my application will not be processed until the registration fee is paid unless prior arrangements have been made with the director.

_____ I understand that one month's tuition is due by July 24, 2026 THIS TUITION WILL BE APPLIED TO MAY 2027.

_____ I understand that the tuition rate is figured over a nine month period and that there are no deductions for absences, vacation time or inclement weather days. This includes extended day tuition.

_____ I understand that I must give a 30 day written notice to withdraw my child from Pioneer Preschool.

_____ I understand that the following forms are required by the state of Kansas.

1. Kansas Authorization for Emergency Medical Care
2. Kansas Medical record forms including: (1) medical record completed and signed by parent, (2) history of immunizations and (3) child's health assessment completed and signed by your child's physician.

ALL FORMS MUST BE ON FILE BEFORE MY CHILD CAN ATTEND PIONEER PRESCHOOL

These forms can be picked up at the preschool office or they are available on the preschool website.

Parent Signature: _____ Date: _____

Medical Record:

Medical History Cont. - 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 <small>*Recommended <8 mo.; not required</small>						
Influenza (Flu) <small>*Recommended annually >6 mo.; not required</small>						

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 Hep A Hep B
 Hib PCV Varicella Other (describe): _____

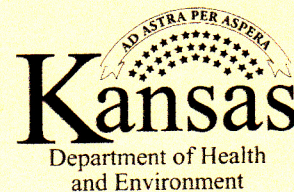
Physician's Signature (required): _____ Date: _____

(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 Care Licensing Program
Curtis State Office Building
Kansas Department of Health and Environment
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 | Fax 785-559-4244
Email: kdhe.cclr@ks.gov | kdhe.ks.gov/Childcare Licensing



Medical Record: Child Health Assessment

The Child Health Assessment form is to be completed and signed by a nurse approved to perform health assessments, a licensed physician, or physician's assistant (PA). The health assessment shall be conducted not more than 12 months before and no later than 60 calendar days after enrollment at the child care facility.

A Child Health Assessment, recorded on a KDHE Form or other acceptable Forms mentioned below, is required for all children including children of the provider or staff in Family Child Care Homes, Child Care Centers, and Preschools. A Kan-Be-Healthy Assessment Form is a KDHE Form and is acceptable, a Physician Health Assessment Form is acceptable, and a School Health Assessment Form is acceptable for school-age children or youth.

Child's Name _____ **Date of Birth** _____
First Last

Health history and medical information pertinent to routine child care and emergencies (describe, if any): <input type="checkbox"/> None	Do you see this child for regular health supervision: <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to food or medicine (describe, if any): <input type="checkbox"/> None	
List current medications (if any): <input type="checkbox"/> None	

Length/Height: _____ IN/CM %ILE	Weight: _____ LB/KG %ILE	
Physical Examination	✓ If Normal	If Abnormal - Comments
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardio/Respiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic & Developmental		
Screening Tests	Screening Date	Note Here if Results are Pending or Abnormal
Lead		
Anemia (HGB/HCT)		
Urinalysis (UA)		
Hearing		
Vision		
Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (Attach additional pages if necessary) <input type="checkbox"/> None		
Signature of Licensed Physician or Nurse approved for Child Health Assessment		Date
Print the Name of the Individual Signing Above		Phone Number
Address	City	Zip Code

Curtis State Office Building
Kansas Department of Health and Environment
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 | Fax 785-559-4244
Email: kdhe.cclr@ks.gov | kdhe.ks.gov/ChildCareLicensing



Authorization for Emergency Medical Care

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A). School Age Programs reference K.A.R. 28-4-582(e)(2).

Name of facility exactly as stated on the license PIONEER PRESCHOOL CHILD CARE CENTER	License # 0015266-021
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I authorize _____ (caregiver/staff) who is/are representative(s) of the above-named facility to give consent for any and all necessary emergency medical care for my child or youth _____ (child's first and last name) while child or youth is in the facility's custody between 08/25/2026 and Until no longer in our care.
MM/DD/YYYY MM/DD/YYYY

List any known allergies or other information about the medical conditions of this child or youth pertinent in case of emergency:

Signature of Parent or Guardian	Date Signed
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The Medical Record/Assessment Form (Or Health Status History form for School Age Programs) and the authorization for Emergency Medical Care must be taken to the emergency room. Both forms must also be in a vehicle when the child or youth is off premises from the facility.