

# Little Griffins Preschool



Preschool program for Diller-Odell  
Children ages 4 and 5.

Diller-Odell Public Schools

Dear Parents/Guardians,

We are excited to offer families in our communities a wonderful educational opportunity for their children! **Little Griffins Preschool**, located in the elementary building, provides a high-quality educational environment where children who are **four years old on or before July 31 of the current calendar year** can learn and grow in a variety of ways.

We offer an **all-day preschool program Monday through Thursday from 8:10 a.m. to 3:30 p.m.**

## Family Involvement

Family interaction and involvement are essential components of early childhood education. The goal of our preschool program is to create a learning environment that actively includes parents and guardians.

Mrs. Kostal will conduct **two home visits per year** with each family.

- The **initial home visit** will include an assessment of the child's strengths and the development of individual goals.
- The **second home visit**, held during the second semester, will focus on transition information for the following school year or kindergarten.

Diller-Odell Public Schools will share resources with families and provide information related to developmental stages and your child's growth.

## Assessment

Diller-Odell Public Schools uses **Teaching Strategies GOLD** as the early childhood assessment tool. This comprehensive system supports teachers in creating age-appropriate learning experiences, meeting children at varying developmental levels, and involving families to ensure students are developing appropriately.

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## Tuition Information (Sliding Fee Scale)

### Little Griffins Preschool Tuition (August–May)

- **Special Education (IEP):** No Cost
- **Free Meal Program Eligibility:** No Cost
- **Reduced Meal Program Eligibility:** \$55.00 per month
- **Full-Pay Meal Program Eligibility:** \$110.00 per month

Annual tuition for full-pay families is divided into **nine payments of \$110**.

- The **first payment is due on or before August 15** and covers **August and May**.
- Remaining payments are due on the **first of each month beginning September 1**.

Other payment options include **quarterly, semester, or annual payments**.

Failure to submit tuition payments may result in discontinued enrollment.

## Meal Program

Little Griffins Preschool provides **nutritionally balanced meals** for participating children. All children will also be offered a **daily snack**.

**Meal Program (4 days per week):**

- **Free Meal Eligibility:** No Cost
- **Reduced Meal Eligibility:**
  - Breakfast: \$0.30
  - Lunch: \$0.40
- **Full-Pay Eligibility:**
  - Breakfast: \$1.75
  - Lunch: \$2.75

*Please note: Lunch prices may change when updated state guidelines are released in July.*

## Enrollment Information

Preschool enrollment guidelines are designed to maximize support for students and families within our communities.

- **Enrollment Period:** January 1 – March 15
- **Notification of Acceptance:** After April 1

**Enrollment Priority:**

1. Children living within district boundaries
2. Preschool-eligible children
  - Must be **4 years old on or before July 31**
3. Income eligibility
4. Students with disabilities
5. English learners
6. Date the application is completed

# Required Documentation

Please return all enclosed forms to:

## **Little Griffins Preschool**

PO Box 8  
315 Smith Street  
Diller, NE 68342

Forms may also be delivered to **Dawn** at the elementary office in Diller.

To attend preschool, families must submit:

- A copy of the child's **birth certificate**
- Current **immunization records**

These documents must be received **prior to the start of preschool in the fall.**

Families will be notified of formal acceptance once applications are received. The preschool handbook and policy information will be available prior to the start of school through the district website.

# Little Griffins



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## Preschool 2026-2027 Application

### CHILD INFORMATION:

Child's Legal Name: Last \_\_\_\_\_ First \_\_\_\_\_

Race Black White Native American Asian Pacific Islander

Child's SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: **F** **M** Age: (Years-Months) \_\_\_\_\_ - \_\_\_\_\_ Birthday \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Primary Language: \_\_\_\_\_ Secondary Language: \_\_\_\_\_ English Prof \_\_\_\_\_ (O-None, 1-Poor, 2-Moderate, 3-Proficient)

Nationality \_\_\_\_\_ (El-Salvador, GU-Guatemala, MX-Mexico, PH-Philippines, PR-Puerto Rico, US-United States, VI-Vietnam, Other \_\_\_\_\_) Ethnicity \_\_\_\_\_ (FI-Filipino, GU-Guamanian, HI-Hispanic, MC-Mexican, Chicano, PR-Puerto Rican, VT-Vietnamese, WH-White (Non-Hispanic) Other \_\_\_\_\_)

### FAMILY INFORMATION:

Primary Adult/Guardians \_\_\_\_\_

Living Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_ Email: \_\_\_\_\_

Phone: First Contact # \_\_\_\_\_ Cell \_\_\_\_\_ Home \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Second Contact # \_\_\_\_\_ Cell \_\_\_\_\_ Home \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Place of Work: \_\_\_\_\_ Contact# \_\_\_\_\_

Foster Parent: **Yes** **No** Parental Status: **One-Parent** **Two-Parent**

No. Persons: **In Family** \_\_\_\_\_ No. Children: **In Family** \_\_\_\_\_

### HEALTH CARE/INSURANCE INFORMATION:

Private Health Insurance Company: \_\_\_\_\_

Does Child have an Educational Disability (IEP)? **Yes** **No** Suspected

Describe \_\_\_\_\_

Diagnosed By: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

Is the child receiving services? **Yes** **No** Who is the provider: \_\_\_\_\_

Does child have special needs or health problems? **Yes** **No**

Describe: \_\_\_\_\_

Referred to program by other agency/professional? **Yes** **No** By Whom & Why \_\_\_\_\_

Any specific family need or crisis? **Yes** **No** Describe: \_\_\_\_\_

Does the family receive Public Assistance Benefits: **Yes** **No** List the Benefits Received: \_\_\_\_\_

**ALLERGIES and MEDICAL ISSUES:**

*Note: Medication must be supplied by parent(s)/guardian(s) and sent in the original container that details doctor's orders. Parent must also fill out the authorization for self-administration of medications at school and turn return to office (the doctor must sign this form) before any medication can be given. If your child has Asthma, a separate form will need to be filled out after the start of school.*

(Please circle Yes or No to the following questions:)

Chicken Pox                    yes     no     Date \_\_\_\_\_

Bee/wasp Sting Allergy    yes     no     Medication \_\_\_\_\_

Asthma                        yes     no     Medication \_\_\_\_\_

Medicine/Drugs            yes     no     Medication \_\_\_\_\_

Food Allergies \_\_\_\_\_

Other Allergies \_\_\_\_\_

Is student currently taking medication/drug? If yes, what kind? \_\_\_\_\_

Does student have epilepsy or other seizure disorder? Yes \_\_\_ No \_\_\_

Other: Corrective glasses/contact lens, hearing impairment, or health (physical or emotional) or behavioral problems \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Do you carry Health Accident Insurance? Yes \_\_\_ No \_\_\_ Carrier's Name \_\_\_\_\_

Do you have other children in your household? Please include pre-school children.

Last name	First name	Middle Name	Date of Birth	Grade & School (if attending)

**CERTIFICATION:** I certify that this information is true. If any part is false, my participation in this school district's programs may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the school district and is accessible to me during normal business hours.

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Please Note: A copy of the child's birth certificate and immunizations record will be needed prior to the start of preschool.*