Dear Parents,

This is the Preschool Application that you have requested for your child. Please be sure to fill the Preschool Application out completely including the doctor and dentist's names and phone numbers on the Medical Emergency Form.

Below are a few requirements that you will need to know before returning the application.

1) A $30.00 non-refundable supply fee will be due once your child is accepted into the preschool program. **Do not send any money with the application.** You will be billed for this at a later date.

2) Verification of Income **must** be sent with the application. Verification of income can be in the form of a pay stub, W-2, 1040 tax form, or medical card. **APPLICATIONS WILL NOT BE PROCESSED WITHOUT THIS INFORMATION**. Preschool tuition is based on a sliding fee schedule according to family size and income. Enrollment priority is given to income eligible families and children with an IEP. Income eligibility is based on the income earned and total number of family members living in your home.

3) **The Medical/Physical Form and Dental Health Record must be turned in within 30 days of enrollment and every 13 months thereafter while your child attends preschool.** If these are not turned in within 30 days, your child will not be able to attend preschool. You can send the preschool application in before these forms are completed. If your child is returning to the preschool program for a second year, the Dental Health Record is not required.

   This includes a medical statement and current list of immunizations. We hope your child has a regular medical provider from whom he/she receives on-going medical care and follow-up. If your child does NOT have a regular medical provider, please inform your child's teacher so that we may assist, as appropriate, in helping you locate a local provider.

   We have enclosed a copy of Lead Testing Requirements and Medical Management Recommendations per Ohio Department of Health. If your child has already been screened, please provide a copy of the results for your child's file as required for preschool licensing. If your child has NOT yet been screened as required, please discuss with your child's physician/health care provider the need to do so and forward results to our office. The purpose of this policy is to ensure the children's safety as much as possible.

4) Send copies of your child's social security number, shot record, certified birth certificate, and custody papers (if applicable). Returning students do not need to send this information unless custody has changed since the previous school year.

5) A Parent Handbook that contains all policies and procedures will be handed out before the first day of school.

Please return the application and all other documentation to:

NPESC – Adams Building
Attn: Preschool
318 Columbus Avenue
Sandusky, OH 44870

If you have any questions, please call Debbie Graber at 419-627-3990 between the hours of 9:00 a.m. – 3:00 p.m.

Sincerely,

Dennis Blanchard, Principal
South Central Elementary/Jr. High School

PRESCHOOL APPLICATION
2014 - 2015 School Year

South Central Preschool Program
3291 Greenwich Angling Road
Greenwich, OH 44837
419-752-6233

For office use:
Date received: _____
Returning student: yes no

Please circle the preferred choice: **AM class** **PM class** (Class choice is not guaranteed.)

Child's Full Name_____
Last First Middle (full middle name)
Child's nickname (name to be called in class)_____
Birthdate_____ Age_____ SS#_____
Address_____
Street City Zip
City and State of child's birth_____ Male or Female (circle)
Parent(s)/Guardian(s) name_____
County of residence_____ School district_____
Home telephone_____ Emergency number_____
Father's employer_____ Phone number_____
Employer's address_____ Work schedule_____
Mother's employer_____ Phone number_____
Employer's address_____ Work schedule_____

List names of people authorized to pick your child up from school (must be over 18 years of age)

_____ _____
_____ _____
_____ _____

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FAMILY INFORMATION

Name of sibling	Age	Name of sibling	Age
_____	_____	_____	_____
_____	_____	_____	_____

Names of others who reside in the home	Relationship to child
_____	_____
_____	_____

What language did your son/daughter speak when he/she first learned to talk? _____

What language does your son/daughter use most frequently at home? _____

What language do you use most frequently to your son/daughter? _____

What language do the adults at home most often speak? _____

How long has your son/daughter attended school in the United States? _____

INTEREST SURVEY

Dear Families,

To help us understand and better communicate with your child, please take a few minutes to complete this Interest Survey. The information will help us be able to make your child feel more at ease at school. (And besides that, it's fun for us to read!)

Child's Name: _____

Nickname: _____ (Child's name as you want them to recognize it in print.)

Brother's/Sister's Name(s) and Ages: _____

_____

Babysitter's Name: _____

Friend's Name(s): _____

Favorite Toy(s): _____

_____

Favorite Food(s): _____

_____

What does he/she call grandparents? _____

_____

Any pets and their names: _____

Any other people, events, etc. your child especially likes/dislikes to talk about: _____

_____

_____

Is there anything of which your child is fearful? If so, what are some ways he/she is calmed?

_____

_____

_____

What are your hopes for your child's preschool experience this year? (What is most important to you, such as experiences, opportunities, skills, etc.?) _____

_____

_____

What hobbies or special skills would you be willing to share? _____

_____

VERIFICATION OF INCOME

_____ _____
Name of Child Birthdate

Verification of current employment and salary is needed in order to determine the preschool program tuition for your child.

List all household members

_____ _____
_____ _____
_____ _____
_____ _____

Total yearly salary_____

Please attach one of the following:
_____W-2
_____Check stub
_____Medical card
_____Other_____

_____ _____
Print name of parent/guardian Social security number

_____
Street address, City, Zip

_____
Home phone number

Penalties for misrepresentation
I certify that all of the about information is true and correct and that all income is reported. I understand that this information is being given for receipt of state funds, that program officials may verify the information on the application, and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal criminal laws.

_____ _____
Signature of parent/guardian Date

<u>For Office Use</u>

_____ _____
Signature of person verifying income Date

CONSENT TO RELEASE CHILD'S PHOTO/VIDEO AND OTHER INFORMATION

To publicize the achievements of our preschool students and the great work they do, we like to occasionally publish our students' names, photos, and/or achievements in our school publications or release the information to local newspapers. We may also post the information on the school's website.

We understand that you may not want to have your child's name, photo, and/or achievements published. Please fill out this form to let us know your wishes.

School district_____ Classroom teacher_____

Student's name_____

- ☐ I consent to have my child's name, photo, and/or achievements published in school newspapers/newsletters, release to local newspapers, and posted on the school's website as it relates to activities and participation in the preschool program.

- ☐ I do not want my child's name, photo, and/or achievements published in school newspapers and/or newsletters, released to local newspapers or posted on the school's website.

_____ _____
Parent/Guardian Signature Date

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CONSENT FOR PARENT ROSTER

In accordance with Rule 3301-37-04 of the Ohio Revised Code, a roster for each classroom, which includes names, addresses and telephone numbers of parent(s)/guardian(s) of children attending the preschool program must be prepared annually and given to parents/guardians upon request, but to no other person.

_____I would like my name and telephone number to be included in this roster.
_____I would not like my name and telephone number to be included in this roster.

_____ _____
Parent/Guardian Signature Date

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CONSENT FOR FIELD TRIPS

_____ My child has permission to attend all school-sponsored field trips during the present school year. Written notice of each field trip will be sent home with your child.

_____ _____
Parent/Guardian Signature Date

EMERGENCY/MEDICAL/TRANSPORTATION AUTHORIZATION FORM

Child's name_____ Grade_____ Telephone_____
Address_____
Social security number_____
School district_____ Building_____

The purpose of this form is to enable parent(s)/guardian(s) to authorize the provision of emergency treatment for your child who becomes ill or injured while under school authority, when you cannot be reached.

Residential parent(s)/guardian(s)
Mother/guardian name_____Phone:Work_____Home_____Cell_____
Father/guardian name_____Phone:Work_____Home_____Cell_____

Contact information if parents cannot be reached in case of emergency: **(2 contacts required)**

Name_____ Phone_____
Address_____Cell_____

Name_____ Phone_____
Address_____Cell_____

PART I OR PART II MUST BE COMPLETED

Part I: To Grant Consent

I hereby give consent for the following medical care providers and local hospital to be called.

Physician_____ Phone _____
Dentist_____ Phone _____
Medical specialist_____ Phone _____
Local hospital_____ Emergency room phone_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

List all allergies and any special precautions or treatments indicated for these allergies. _____
_____

List any medications, food supplements, modified diets, or fluoride supplements currently being administered to the child.
_____

List any chronic physical problems and any history of hospitalizations. _____
_____

List any diseases the child has had. _____

Has your child had chicken pox?_____

Signature of parent/guardian_____ Date_____
Address_____

Part II: Refusal to Consent

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action_____
_____

Signature of parent/guardian_____Date_____
Address_____

Rev. 1/22/13

MEDICAL/PHYSICAL FORM

Child's Name_____DOB_____School_____
Parent/Guardian Name_____Phone_____
Address_____

Required For Children Enrolled In An Early Childhood Education Grant Program Or Preschool Special Education Program				**Reason Not Completed (Check Which Applies)**	
Assessments/Screenings	Completed **(Circle One)**		Date Completed	Health Professional Decision	Examples: religious conviction, insurance coverage, other
Lead	Yes	No			
Hemoglobin	Yes	No			

PHYSICAL ASSESSMENT

HEIGHT: _____ WEIGHT: _____

Did the examination reveal any abnormalities in the following areas?

	YES	NO		YES	NO
General Appearance	☐	☐	Heart/BP_____	☐	☐
Skin	☐	☐	Lungs	☐	☐
Lymph Nodes	☐	☐	Abdomen	☐	☐
Eyes/Vision	☐	☐	Genitalia	☐	☐
Ears/Hearing	☐	☐	Skeletal system	☐	☐
Nose/Throat	☐	☐	Neuro muscular	☐	☐
Teeth/Gums/Dental	☐	☐	Allergies	☐	☐
Tongue/Palate	☐	☐	Specify_____		

Immunizations	**Circle One**	
Complete For Age	Yes	No
In Process	Yes	No

****IMMUNIZATION RECORD MUST BE ATTACHED.****

EXEMPT FROM IMMUNIZATIONS	**Circle One**	
Religious Conviction	Yes	No
Health Concern	Yes	No
Other:		

Limitations or Health Condition (including allergies, medications, dietary restrictions)_____

_____

_____

This child has been examined and is in suitable condition to participate in group care.	
_____ Signature of Examining Physician or Physician's Assistant or Advanced Practice Nurse **(circle one)** Address: _____ Phone: _____	Date of Exam

DENTAL HEALTH RECORD

Child's name_____DOB_____School_____
Parent/guardian name_____Phone_____
Address_____

1. Has the child previously seen a dentist? ☐ No ☐ Yes Dentist's Name_____
2. Does the child have any trouble with teeth, gums, or mouth? ☐ No ☐ Yes
3. Oral condition before treatment: ☐ Missing ☐ Decayed ☐ Filled
4. Examination and treatment record

tooth letter	surface	description of work	date service performed	procedure number

8. Is baby bottle tooth decay present? ☐ No ☐ Yes

9. Is the child receiving: Topical Fluoride Application? ☐ No ☐ Yes
Fluoride Supplement Diet? ☐ No ☐ Yes If yes, tablets ___liquid____
Fluoridated water? ☐ No ☐ Yes

10. Is all planned treatment complete? ☐ No ☐ Yes If not, itemize on chart below.

tooth letter	surface	description of work

11. Approximate number of visits required for treatment? _____

12. Next scheduled appointment_____

13. Comments: _____

Dentist's Name_____
Street Address_____
City, State, Zip_____ Phone_____

Dentist's Signature_____ **Date of examination**_____