WESTERN RESERVE LOCAL SCHOOLS

"Home of the Rough Riders"

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. 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 shot record, certified birth certificate, and custody papers (if applicable). Returning students do not need to turn in 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:

North Point ESC
Attn: Preschool
180 Milan Avenue, Suite 6
Norwalk, OH 44857

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

Sincerely,

Julie Blankenship
Preschool Teacher

PRESCHOOL APPLICATION
2019 - 2020 School Year

Western Reserve Preschool
3851 U.S. Route 20 East
Collins, OH 44826
419-660-9824

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____________ Male or Female (circle)
Address____
Street City Zip

City and State of child's birth____

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

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

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

VERIFICATION OF INCOME FORM

____ _________________________________

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

For Office Use

____________________________________ _________________________________

Signature of person verifying income Date

Ohio Department of Job and Family Services
Ohio Department of Education

EARLY CHILDHOOD EDUCATION ELIGIBILITY SCREENING TOOL

How do I apply for Early Childhood Education Services?	**You will need to:** **1.** Complete the screening tool. **2.** Do not submit to the Ohio Department of Education. **3.** Submit this form to your provider.
How do I apply for Publicly Funded Child Care?	**You will need to:** **1.** Complete the screening tool, JFS 01121. **2.** Complete the JFS 01122 Publicly Funded Child Care Supplemental Application. **3.** Submit both the JFS 01121 and JFS 01122 to your local county agency. **4.** Attach verifications to the JFS 01122 (see verification requirements below).
How do I complete this application?	**1. Fill out this application:** Answer as many questions as you can. **2. Be sure to sign the application.**
When will I receive assistance?	**ECC:** You will be notified by your provider when you may begin care. **Child care:** Eligibility for the child care program is based on the date a signed application is submitted to the county agency. Eligibility for this program is determined within 30 days from the earliest date either the JFS 01121 or JFS 01122 is submitted.
What verifications do I need for publicly funded child care?	**You will need to:** **1. Submit the JFS 01121 and JFS 01122.** **2. Provide proof of income:** Verification of all money coming into your household. (such as pay stubs, tax records, award letters, child support) **3. Proof of any child support paid.** **4. Proof of citizenship or qualified alien status for children in need of care:** If the county agency verifies that a caretaker receives or has received OWF for a child, verification of citizenship is not required. **5. Provide proof of a qualifying activity for all caretakers in the household:** Verification of a qualifying activity includes but is not limited to an official school schedule, work schedule, employment verification, self-sufficiency contract, etc. **6. Provide the name and address of an eligible child care provider chosen for each child in need of care.**
What is Step Up To Quality?	**Step Up To Quality was created to help families identify early learning and development programs that go beyond the minimum standards of licensing. Star Rated programs demonstrate higher levels of quality in a variety of ways. Ask your provider if they are participating.**

Tell us about your needs for your child(ren)

Child 1	Provider Name and Address	Child's Needs	What hours/days do you need services? (i.e. child care or preschool) Check all that apply
Name Child's Mother's Maiden Name Child's City of Birth		Do you have concerns about your child's growth and/or development? ☐ Yes ☐ No Describe: ____________	☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends **What is the child's home school district?** ____________

Child 2	Provider Name and Address	Child's Needs	What hours/days do you need services? (child care or preschool) Check all that apply
Name Child's Mother's Maiden Name Child's City of Birth		Do you have concerns about your child's growth and/or development? ☐ Yes ☐ No Describe: ____________	☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends **What is the child's home school district?** ____________

Child 3	Provider Name and Address	Child's Needs	What hours/days do you need services? (child care or preschool) Check all that apply
Name Child's Mother's Maiden Name Child's City of Birth		Do you have concerns about your child's growth and/or development? ☐ Yes ☐ No Describe: ____________	☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends **What is the child's home school district?** ____________

Please Print

Western Reserve Elementary
Emergency Medical Authorization
2018-2019

Student Name______________________________ Grade________ Teacher_____________
Address___________________________________ City___________ Zip_____________
Home Phone___________________________ Date of Birth___________________________

Purpose-To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Part I – To Grant Consent

Emergency Contacts

Please list contacts that can come when your child needs to leave school.

Legal Guardian is: Mother___ Father___ Both___ Other (Name) ______________________
Parents are: Married_____ Divorced_____ Widowed_____ Single_____

Mother's Name____
Address____________________________ City____________________ State_______ Zip________
Home #____________________ Cell #____________________ Daytime #____________________
Email Address____

Father's Name____
Address____________________________ City____________________ State_______ Zip________
Home #____________________ Cell #____________________ Daytime #____________________
Email Address____

Emergency Contact (Non Parent) ___________________________ Relationship_______________
Home #___________________ Cell #___________________ Daytime #_____________________

Emergency Contact___________________________________ Phone___________________
Physician____ Phone___________________
Dentist____ Phone___________________
Hospital Preference_________________________________ Phone___________________

In the event reasonable attempts to contact me have been unsuccessful, I herby give my consent for (1) the administration of any treatment deemed necessary by above-named physician/dentist, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the 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.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

____

Parent/Guardian Signature: ____________________________________ Date ______________

Do not complete Part II, if Part I is completed

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:

____

Parent/Guardian Signature: ____________________________________ Date:______________

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.

	Date of Exam
______________________________________ Signature of Examining Physician or Physician's Assistant or Advanced Practice Nurse **(circle one)** Address: ______________________________ Phone: ______________________________	

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 or number	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**__________