



2022 – 2023 Preschool Enrollment

Preble County Educational Service Center
 597 Hillcrest Drive, Eaton, OH 45320
 Phone: (937) 456-1187 Fax: (937) 456-3253
www.preblecountyesc.org

The following forms **MUST** be completed and returned to assure enrollment in a Preble County Educational Service Center Preschool classroom. This enrollment packet will **NOT** be accepted unless all required information is included. We will be happy to copy any documents for you.

STUDENT NAME: _____ **BIRTH DATE:** _____

Is this a returning student? _____ YES _____ NO

REQUIRED COMPLETED FORMS

- | | |
|--|---|
| <input type="checkbox"/> Registration Form | <input type="checkbox"/> Emergency Medical Authorization Form |
| <input type="checkbox"/> Student Information Form | <input type="checkbox"/> Agreement and Permission Form |
| <input type="checkbox"/> Release Form for Video | <input type="checkbox"/> Early Childhood Education Eligibility Screening Tool (3 pages) |
| <input type="checkbox"/> Tuition Agreement Form (Not applicable to IEP students) | |

REQUIRED DOCUMENTATION

- | | |
|--|---|
| <input type="checkbox"/> Copy of Birth Certificate | <input type="checkbox"/> Copy of Social Security Card |
| <input type="checkbox"/> Copy of Proof of Income (tuition students only) | <input type="checkbox"/> Copy of Proof of Residence (IEP students only) |
| <input type="checkbox"/> Child Medical Statement (due within 30 days of school) | <input type="checkbox"/> Copy of Custody documentation of student (if applicable) |
| <input type="checkbox"/> Dental Form (due within 30 days of school) | <input type="checkbox"/> Immunization/Shot Record |

PARENT PREFERENCE PLACEMENT (Please rate each session below by number in order of preference):

ECE Program
 _____ AM ESC Office 8:25-11:40 am
 _____ PM ESC Office 12:10-2:55 pm

PSE Program
 _____ AM ESC Office 8:25-11:10 am
 _____ PM ESC Office 12:10-2:55 pm

*We do not guarantee placement choice, but will take preference into consideration.
 The times above are tentative.*

If transportation is available, would you be interested? _____ YES _____ NO

2022-2023 PRESCHOOL REGISTRATION FORM

STUDENT INFORMATION:

LEGAL NAME: _____
First Name Middle Last Name

DATE OF BIRTH: _____ BIRTH PLACE: _____ SS# _____

ADDRESS: _____
Street City State Zip

GENDER: MALE FEMALE ETHNICITY: Hispanic/Latino
 Non-Hispanic-(If checked you must choose one or more of the following :)
 Black/African American White
 American Indian or Alaska Native Asian Native Hawaiian/Pacific Islander

PARENT/GUARDIAN INFORMATION:

MOTHER'S NAME: _____
First Middle Last Maiden

(DO NOT COMPLETE UNLESS DIFFERENT FROM STUDENT'S ADDRESS)

ADDRESS: _____
Street City State Zip

EMAIL ADDRESS: _____

MARITAL STATUS: Married Single Divorced Widowed

PHONE NUMBER (HOME): _____ MILITARY STATUS: Active Duty
 Active Reserve

PHONE NUMBER (CELL): _____

PHONE NUMBER (WORK): _____

EMPLOYER: _____ OCCUPATION: _____

PARENT/GUARDIAN INFORMATION:

FATHER'S NAME: _____
First Middle Last Maiden

(DO NOT COMPLETE UNLESS DIFFERENT FROM STUDENT'S ADDRESS)

ADDRESS: _____
Street City State Zip

EMAIL ADDRESS: _____

MARITAL STATUS: Married Single Divorced Widowed

PHONE NUMBER (HOME): _____ MILITARY STATUS: Active Duty
 Active Reserve

PHONE NUMBER (CELL): _____

PHONE NUMBER (WORK): _____

EMPLOYER: _____ OCCUPATION: _____

BROTHERS & SISTERS:

| <u>NAME</u> | <u>DATE OF BIRTH</u> | <u>SCHOOL BUILDING</u> | <u>GRADE</u> |
|-------------|----------------------|------------------------|--------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

PLEASE COMPLETE IF YOUR CHILD IS USUALLY CARED FOR DURING THE DAY BY SOMEONE OTHER THAN PARENT

NAME OF CAREGIVER: _____ RELATIONSHIP: _____

ADDRESS: _____
Street City State Zip

PHONE NUMBER (Home): _____ PHONE NUMBER (Cell): _____

EMERGENCY MEDICAL AUTHORIZATION

Student Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip Code: _____

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.

Mother's Name: _____ Daytime Phone #: _____

Father's Name: _____ Daytime Phone #: _____

Other's Name: _____ Daytime Phone #: _____

Name of Relative or Childcare Provider: _____ Relationship: _____

Phone: _____ Address: _____

PART I OR 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:

Doctor: _____ Phone: _____ Address: _____

Dentist: _____ Phone: _____ Address: _____

Hospital/ER: _____ Phone: _____ Address: _____

Medical Specialist: _____ Phone: _____ Address: _____

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 doctor, 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 dentist, 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, medication being taken, and any physical impairments to which a physician should be alerted:

Signature of Parent/Guardian: _____ Date: _____

Address: _____
Street City State Zip

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: _____
Street City State Zip

Preble County Preschool Student Information Form

Student's Name: _____
 First Middle Last

Nickname: _____ Date of Birth: _____

1. List all the food or environmental allergies and any special precautions and treatment indicated for these allergies: _____

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

3. List any chronic physical problems and any history of hospitalization: _____

4. List any diseases the child has had: _____

5. Does your child have any habits we should be aware of? _____

6. Does your child have any fears we should be aware of? _____

Alternate Contacts – Others who may pick up my child in the event of an emergency (and when parents cannot be reached). You **MUST** have at least **3** alternate contacts. My child may be released to the following persons:

| NAME | ADDRESS | PHONE | RELATIONSHIP |
|------|---------|-------|--------------|
| | | | |
| | | | |
| | | | |
| | | | |

Signature of Parent/Guardian _____ Date _____

PRESCHOOL AGREEMENT & PERMISSION FORM

Student's Name: _____
First
Middle
Last

Address: _____
Street
City
State
Zip

Parent/Guardian Name: _____

| YES | NO | |
|-----|----|--|
| | | 1. I agree that my child may go on scheduled class fieldtrips. I understand that I will be informed of all fieldtrips before the scheduled day. |
| | | 2. I agree that any photo of my child may be used in newspapers, classroom displays, yearbooks, and/or other types of educational publications, including videos for educational presentations. |
| | | 3. I agree to allow the Preble County Preschool teaching staff to make home visits during the school year at my convenience. |
| | | 4. I agree to notify the Preble County Preschool teaching staff immediately of any changes in the drop off or pick up of my child. |
| | | 5. I understand that my child may receive a developmental screening as required by the state of Ohio and that any concerns/recommendations will be discussed with me at a conference. |
| | | 6. I authorize the Preble County Preschool to release enrollment information, as well as any information pertinent to my child's education to my local school district. I understand that this information will remain confidential. |
| | | 7. I agree to notify the Preble County Preschool staff of any change in household income. |
| | | 8. I agree that my child's name, my name, address, and telephone number may be included in the Class Roster which will be made available to the parent of each child in the program. |
| | | 9. I agree that my child may be involved in small group and large group activities with the speech therapist or intervention specialist in the classroom. |
| | | 10. I agree that my child may be videotaped in order to collect data for their Early Learning Assessment and/or IEP goals if applicable. Videotapes will only be shared with appropriate staff. |

Signature of Parent/Guardian _____ Date _____

Dear Parent/Guardian:

The Preble County ESC believes in high quality professional development that allows our teachers to improve their teaching practices. As part of this process, our program uses video recording of instruction time in the classroom in order to analyze teaching practice, identify strength and weakness areas of teacher, and reflect on ways the teachers can improve their teaching practice in the future.

We also use video recording to analyze student behavior and develop behavior and other educational plans as needed. Collected video recordings will not be shared outside of preschool or Preble County ESC staff.

We ask that parents sign the release below in order to give permission for your child to be video recorded for the above described reasons.

Sincerely,

Deb Barnett
Preble ESC Preschool Supervisor



Student Name: _____

School/Teacher: _____

I am the parent/legal guardian of the child named above. I have received and read the letter regarding video recording for the purposes of teacher professional development and/or student behavior plans or other educational plans.

Please check the appropriate box:

I **DO** give my permission for you to include my child's image on video recording as he or she participates in class conducted by _____ in the Preble County ESC Preschool program.
(Teacher's Name)

I **DO NOT** give my permission to video record my child or to reproduce materials that my child may produce as part of classroom activities.

Signature of Parent/Guardian _____ Date _____

Ohio Department of Job and Family Services
Ohio Department of Education
EARLY CHILDHOOD EDUCATION ELIGIBILITY SCREENING TOOL

| Tell us about you (the applicant) | | | |
|-----------------------------------|-----------------------------------|----------------|--------------|
| First Name | MI | Last Name | |
| Address | | | Today's Date |
| City | State | County | Zip Code |
| Phone Number () | Additional Phone Number () | E-mail Address | |

| Tell us about the people in your home | | | | | | | |
|---------------------------------------|---|---|-------------------------------------|-----------------|---------------|-------------------------|-------------------------------|
| Name <i>(First, Middle, Last)</i> | Relationship to You <i>(spouse, son, friend, etc.)</i> | Race | Hispanic or Latino <i>Y or N</i> | Spoken Language | Date of Birth | Gender <i>M or F</i> | U.S. Citizen <i>Y or N</i> |
| | Self | <input type="checkbox"/> African American <input type="checkbox"/> Alaska Native/American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hawaiian/Pacific Islander | | | | | |
| | | <input type="checkbox"/> African American <input type="checkbox"/> Alaska Native/American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hawaiian/Pacific Islander | | | | | |
| | | <input type="checkbox"/> African American <input type="checkbox"/> Alaska Native/American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hawaiian/Pacific Islander | | | | | |
| | | <input type="checkbox"/> African American <input type="checkbox"/> Alaska Native/American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hawaiian/Pacific Islander | | | | | |
| | | <input type="checkbox"/> African American <input type="checkbox"/> Alaska Native/American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hawaiian/Pacific Islander | | | | | |

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) <i>Check all that apply</i> |
|------------------------------|---------------------------|---|---|
| Name | | Do you have concerns about your child's growth and/or development? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: | <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Mornings <input type="checkbox"/> Afternoons <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends |
| Child's Mother's Maiden Name | | | What is the child's home school district? |
| Child's City of Birth | | | |
| Child 2 | Provider Name and Address | Child's Needs | What hours/days do you need services? (child care or preschool) <i>Check all that apply</i> |
| Name | | Do you have concerns about your child's growth and/or development? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: | <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Mornings <input type="checkbox"/> Afternoons <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends |
| Child's Mother's Maiden Name | | | What is the child's home school district? |
| Child's City of Birth | | | |
| Child 3 | Provider Name and Address | Child's Needs | What hours/days do you need services? (child care or preschool) <i>Check all that apply</i> |
| Name | | Do you have concerns about your child's growth and/or development? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: | <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Mornings <input type="checkbox"/> Afternoons <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends |
| Child's Mother's Maiden Name | | | What is the child's home school district? |
| Child's City of Birth | | | |

Tell us about your finances

Will you or the people in your home receive income this month? Yes No

Income refers to all the money that you and the people in your home receive such as earnings from employment, child/spousal/medical support, disability benefits, retirement benefits, Workers' Compensation, Social Security, SSI, Veterans Benefits, etc.

If yes, please complete the table below.

| Name | Type of Income | Amount of Income <i>(before taxes)</i> | How Often Received <i>(weekly, bi-weekly, etc)</i> | Date Last Received | Work or School Schedule <i>(please list times)</i> |
|------|----------------|---|---|--------------------|---|
| | | | | | <input type="checkbox"/> Sun ____ <input type="checkbox"/> Thurs ____ <input type="checkbox"/> Mon ____ <input type="checkbox"/> Fri ____ <input type="checkbox"/> Tues ____ <input type="checkbox"/> Sat ____ <input type="checkbox"/> Wed ____ |
| | | | | | <input type="checkbox"/> Sun ____ <input type="checkbox"/> Thurs ____ <input type="checkbox"/> Mon ____ <input type="checkbox"/> Fri ____ <input type="checkbox"/> Tues ____ <input type="checkbox"/> Sat ____ <input type="checkbox"/> Wed ____ |
| | | | | | <input type="checkbox"/> Sun ____ <input type="checkbox"/> Thurs ____ <input type="checkbox"/> Mon ____ <input type="checkbox"/> Fri ____ <input type="checkbox"/> Tues ____ <input type="checkbox"/> Sat ____ <input type="checkbox"/> Wed ____ |
| | | | | | <input type="checkbox"/> Sun ____ <input type="checkbox"/> Thurs ____ <input type="checkbox"/> Mon ____ <input type="checkbox"/> Fri ____ <input type="checkbox"/> Tues ____ <input type="checkbox"/> Sat ____ <input type="checkbox"/> Wed ____ |
| | | | | | <input type="checkbox"/> Sun ____ <input type="checkbox"/> Thurs ____ <input type="checkbox"/> Mon ____ <input type="checkbox"/> Fri ____ <input type="checkbox"/> Tues ____ <input type="checkbox"/> Sat ____ <input type="checkbox"/> Wed ____ |

Do you or anyone in your household pay Child or Spousal Support? Yes No

How Much?

Signature of Applicant

Date

PRESCHOOL TUITION AGREEMENT FORM

The Preble County preschool program charges an annual tuition amount for each child on a sliding scale. We do not charge by the hour, or by the day. Instead, we charge for the slot for the year. When a family pays their tuition each week, they are actually paying toward the cost for the slot for the school year.

_____ has my permission to attend the Preble
(*Student's Name*)
County Preschool. I agree to pay the amount of \$_____ for each week of enrollment, and I understand that tuition is due in advance of each week and the first payment due is the first day of school. Subsequent payments are due every first day of the school week thereafter. Tuition will be due regardless of any absences or snow days (excluding Thanksgiving, Winter and Spring Breaks). If I am one week late with my tuition payment, a reminder note will be sent home with my child. If I am two weeks late with my tuition a second notice will be sent home. If I am three weeks behind on my tuition payment, a final notice will be sent home. If I am not able to pay my child's tuition in full within the date specified on the final notice, I understand I will lose my child's placement in preschool.

Parent/Guardian Signature

Date



This form meets Ohio Administrative Code. Programs may use this form or build their own.

Section I - Child Medical Information

Child's Name _____

Date of Birth _____ Height _____ Weight _____

Table with 2 columns: Immunizations and Exempt from Immunization. Rows include Complete for Age, In Process, Religious Conviction, Health, and Other.

Limitations or health conditions, including allergies, medications, and dietary restrictions.

Large empty rectangular box for entering health conditions.

Section II - Child Medical Statement Verification

Physician/Clinic/Hospital Name _____ Provider Address _____

Provider Phone Number _____ Provider City _____ Provider State _____ Provider Zip _____

Check box of examining medical professional:

- Physician
Physician Assistant
Advanced Practice Registered Nurse

This child has been examined and is in suitable condition to participate in group care.

Signature of Medical Professional _____ Date of Exam _____

Programs funded through the Ohio Department of Education must have written policies and procedures to ensure that children have received comprehensive health screenings and/or that families are informed of the importance of health screenings and the resources to obtain them.

PREBLE COUNTY EDUCATIONAL SERVICE CENTER

Early Childhood Programs

597 Hillcrest Dr., Eaton, OH 45320

PH: 937-456-1187

FAX: 937-456-3253

DENTAL FORM

Child's Name: _____

Gender: _____ DOB: _____

Parent/Guardian's Name: _____ Phone: _____

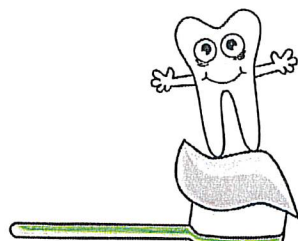
Address: _____ Zip: _____ Teacher: _____


Preventive Services Completed:

Date: _____

Treatment Completed:

Date: _____

 _____ Exam
_____ Prophy
_____ Fluoride
_____ X-rays
_____ OHI

 _____ Restorative
_____ Extractions
_____ Pulpotomy
_____ Sealants

Comments:

Check if treatment is required. How many restorations? _____

Check if all services for this child have been completed.

Check if treatment is discontinued: Reason _____

6-month check up appt. _____ Next Treatment Date: _____

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED

Dentist's Signature: _____

Address: _____ Phone: _____