PCSD

Parma City School District

First Step Preschool Attendance Procedures 2024-2025

When your child will be absent from school,
Please call the office at First Step.

First Step Preschool
440-885-8645

If your child receives PCSD Transportation,
Please call and report their absence.

PCSD Transportation
440-885-2326

FIRST STEP
PRESCHOOL
Where Children Shine and Grow

PCSD
Parma City School District

FIRST STEP PRESCHOOL
EMERGENCY CONTACT/RELEASE FORM

Please print all information clearly.

FIRST STEP PRESCHOOL
Where Children Shine and Grow

Name of Child: _____ Child's Teacher: _____

AM:_____ PM:_____

We are required to have 2 additional **emergency contacts** on file, **OTHER THAN PARENT(S),** in the event the parent(s) cannot be reached. The two additional contacts must be at different households, addresses,and phone numbers. You may use some of the same Permission to Release contacts as listed below.

EMERGENCY CONTACTS

1. Name/Relationship: _____
   Address: _____
   Phone Number(s): _____
2. Name/Relationship: _____
   Address: _____
   Phone Number(s): _____

PERMISSION TO RELEASE CHILD

We are required to have **contact information** for 3 persons, **OTHER THAN PARENT(S)**, to whom the child can be released. The 3 names must be 3 **different** households, addresses, and phone numbers. You may use some of the same Emergency Contacts from above.

1. Name/Relationship: _____
   Address: _____
   Phone Number(s): _____
2. Name/Relationship: _____
   Address: _____
   Phone Number(s): _____
3. Name/Relationship: _____
   Address: _____
   Phone Number(s): _____

***** PLEASE CHECK ONE*****

Do you wish to have your child's name included in the class directory? Yes _____ No _____

First Step Preschool Family Survey

Child's Name:_____ Date of Birth:_____

☐ I have access to the digital student handbook online

☐ I do not need a hardcopy of the student handbook

Do you give permission for your child to use hand sanitizer?

☐ YES
☐ NO

Nickname:_____ Any known Allergies:_____

Parent/Guardian Email Address:_____

Who does your child live with (pets included)? Please list name and relationship.

_____

_____

Religious Affiliation:_____

Are there cultural or religious practices of your family we should be aware of? (dietary restrictions, clothing, head covering, etc.) _____

_____

To align with our Districts Embrace All initiative, do you have any family traditions or talents you would like to share? If so please list belo☐ ☐ ☐

_____

_____

Is your child toilet trained (check one)? independent emerging not yet

Any Special Arrangements (shared parenting, living in two homes, or custody specifications?_____

Is your child adopted? ☐ yes ☐ no At what age? _____

Is your child aware of their adoption? _____

Is your child a foster child? ☐ yes ☐ no

How long has s/he been with your family?_____

Languages spoken at home:_____

How do you discipline your child at home?_____

OVER

How does your child react to discipline?

_____

School History

Has your child attended preschool or daycare before? ☐ yes ☐ no

Where?_____

How Long? _____

Has your child had any group experiences (i.e. library story time, Little Gym, etc)? ☐ yes ☐ no

What kind?_____

What does your child like to do at home?_____

_____

_____

What games or toys does your child prefer?_____

_____

Please circle the words below that describe your child:

Friendly	Moody	Quiet	Aggressive	Good-natured	Emotional
Impulsive	Attentive	Sleepy	Fearful	Even-tempered	Stubborn
Caring	Happy	Shy	Dependent	Sympathetic	Energetic

Does your child enjoy reading books with you? ☐ yes ☐ no

How often do you read at home?_____

Who reads with your child at home?_____

Does your child nap?_____ What time?_____ How long?_____

What time does your child go to sleep at night? _____

What time does your child wake up in the morning?_____

Does your child play well alone? ☐ yes ☐ no

Does your child play well in groups? ☐ yes ☐ no

OVER

Does your child have any fears (i.e. animas, thunder, dark, etc)? _____

What are they?_____

Has your child had to face any difficult situations (hospitalization, moving, divorce, etc)?_____

_____

_____

_____

Does your child have frequent temper tantrums? ☐ yes ☐ no

Describe what might occur that would result in a temper tantrum: _____

_____

_____

Does your child:

Seem to be highly active? ☐ yes ☐ no

Seem to be unusually quiet? ☐ yes ☐ no

Seem to be a happy child? ☐ yes ☐ no

How long can your child attend to something of interest?_____

Do you have any concerns about your child's development (speech, fine motor, behavior)? If so, please explain.

_____

_____

_____

What goals do you have for your child this school year? _____

_____

_____

_____

Is there anything else you would like to tell us about your child?_____

_____

_____

_____

PCSD
Parma City School District

SPECIAL EDUCATION

Date: _____

To the Parent/Guardian of: _____

The Ohio Department of Education is requiring all school districts in the State of Ohio to identify the family income level of preschoolers who attend public school programs. These programs include those children (3-5) with or without disabilities.

Please complete the following questions:

1. **How many members are in your household?** _____

Members of the household include all people living in your home, related or not (such as grandparents, other relatives or friends. You must include yourself and all children,

2. **What is your annual income?** _____

I verify that the above information is correct.

Parent/Guardian Signature: _____ Date:_____

You do have the option to refuse to provide the State of Ohio with this information. If you decline, please indicate on the line provided and sign your name.

I decline to provide the State of Ohio with personal household income amount information at this time.

Parent/Guardian Signature: _____ Date:_____

Thank you for your help in responding to this request from the Ohio Department of Education.

Sincerely,

Parma City School District
Special Education Department

PCSD
Parma City School District

Dear Parent or Guardian,

According to Ohio State Law, all preschool children are required to have a yearly physical form turned in to the school clinic within **30 days** of their admission to the program. This may be completed with information from a physical examination done within the last 365 days (1 year). If a physical expires during the school year, another updated form is required.

We are also required to have a copy of every student's current and age appropriate immunization record attached to the physical form if not already turned in. If your child has had a physical in the last 365 days, you can have the physician fill out the form from that physical.

Attached is the First Step Preschool physical form that should be taken to your child's physician. It is also recommended that children with special needs be evaluated by an eye specialist.

The State of Ohio also requires a dental form from every preschooler. Attached is a copy of the dental form that can be **waived** by having a parent or guardian's signature at the bottom. If your child has seen a dentist, please have them fill out this form.

When completed, please send the physical and dental forms to First Step Preschool.

First Step Preschool
7700 Malibu Dr.
Parma, OH 44130
Fax- 440-842-9832

If you have any questions or concerns, please contact our clinic nurse at 440-885-7085.

Stay Healthy!

First Step Preschool Clinic
Parma City School District
PSI Affiliates, INC. Staff

FIRST STEP
PRESCHOOL
Where Children Shine and Grow!

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)*	Date of Birth

Note: Sections A and B must be completed by the examining Health Care Practitioner (Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner):

Section A- EXAMINATION

√ The above named child has been examined.

√ The above named child is in suitable condition for participation in group care (i.e. free of infectious disease, mentally and physically fit to be in group care).

√ The above named child does not have allergies OR is allergic to the following (*please list in space below*):

Check below, if applicable:

☐ Additional information that will assist the child care program in providing appropriate child care for the above named child (special health care and developmental considerations) accompanies this form.

Optional: Measurements and Recommended Assessments/Screenings

Height _____ Vision _____ ☐ Yes ☐ No Lead _____ ☐ Yes ☐ No

Weight _____ Hearing _____ ☐ Yes ☐ No Hemoglobin _____ ☐ Yes ☐ No

BMI _____ Dental _____ ☐ Yes ☐ No Other: _____

Notes:

Signature of Examining Health Care Practitioner	Date of Examination
Name of Examining Health Care Practitioner	Telephone Number
Street Address	City, State and Zip Code

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD INCLUDING DATES (MM/DD/YYYY FORMAT) OF DOSES OF ALL IMMUNIZATIONS.

IMMUNIZATION (*Complete ONLY ONE SECTION below*)

Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases:
Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.

Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER: ☐ The above named child has been immunized against the diseases listed above. *If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):*	**Initials of Examining Health Care Practitioner**
	Date
Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S): ☐ I have declined to have my child immunized for reasons of conscience, including religious convictions against all of the diseases listed above or against the following disease(s):	**Signature of Parent**
	Date

Ohio Department of Health • School and Adolescent Health

Oral Assessment

Student name	Date of birth

The following services have been performed (please check all that apply)

☐ Examination ☐ Fluoride application ☐ Oral prophylaxis (cleaning) ☐ Prescription for fluoride supplement
☐ Orthodontic assessment ☐ Radiographs ☐ Dental sealant ☐ Treatment (restoration, pulp therapy)
☐ Other_____

The following oral hygiene instruction was provided (please check all that apply)

☐ Toothbrushing ☐ Flossing ☐ Dietary counseling ☐ Use of fluoride mouthrinse
☐ Other_____

The following statements are applicable (please check all that apply)

All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)

☐ No restorative services are required at this time.
☐ Further treatment is indicated. (See comments)
☐ Further appointments have been arranged. (Orthodontic, restorative)
☐ Routine recall visits recommended.

Comments

Dentist's signature	Print name		Phone
Address			Date
City		State	ZIP

HEA 4243 8/06

Please sign here if your child has not yet seen a dentist. This form is able to be waived but still needs to be on file. X_____