



Mohawk Local School District



Administration

Andrew Sprang, Superintendent
Rhonda Feasel, Treasurer
Brooke Bowlin, Elem. Principal
Robert Chevalier, JH/HS Principal
Amy Kozel, Asst. Principal/A.D.
Hannah Herring, Director of
Student Services

295 State Highway 231
Sycamore, Ohio 44882

Elementary Office: 419-927-2595
Jr. High/High School Office: 419-927-6222
Fax: 419-927-2393
Administration Office: 419-927-2414

Board of Education

Lori Arnold
Danielle Clouse
Shawn Detterman
Carl Long
Nichole England

Welcome Preschool Families!

We are very excited to register your child at Mohawk Preschool for the 2026/2027 school year. Registration is currently open and will be until classes are full. Here are some important things to note:

- A spot is not guaranteed for those outside of the district, depending on resident registrations.
- Due to the complexity of preschool requirements and the number of students, we will not be able to accommodate requests for specific teachers.
- Acceptance letters and classroom teacher information will be sent out the first week of July.
- There are two class options; M/W/F is \$195 a month and T/R is \$130 a month and placement will be made by school administrators.
- Registration through Final Forms is required. The link is on the school website.
- A \$50 deposit is required to hold a spot.
- A copy of the birth certificate and child enrollment form are also required to hold a spot for your child.

For more information or questions, please contact the school office at 419.927.2595.

Brooke Bowlin
PK-6 Principal
Mohawk Local Schools

Ohio Department of Job and Family Services
CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name (<i>print or type</i>)	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 (<i>please list in space below</i>):	
<i>Check below, if applicable:</i>	
☐ 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
Weight _____	Lead _____ ☐ Yes ☐ No
BMI _____	Hearing _____ ☐ Yes ☐ No
	Dental _____ ☐ Yes ☐ No
Notes:	Hemoglobin _____ ☐ Yes ☐ No
	Other: _____
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. <i>If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):</i>	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 Job and Family Services
**CHILD ENROLLMENT AND HEALTH INFORMATION
 FOR CHILD CARE**

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name		Date of Birth		First Day at Program/Home	
Home Address				City	
State		Zip Code		Home Telephone Number	
Parent/Guardian Name #1			Relationship to Child		
Home Address ☐ Same as Child's			Home Telephone Number ☐ Same as Child's		
City			State		Zip
Email Address (if applicable)			Cell Phone (if applicable)		
Parent's Work/School Name			Parent's Work/School Telephone Number		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. ☐ Yes ☐ No					
If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email					
Where can you be reached while your child is in this program/home?					
Parent/Guardian Name #2			Relationship to Child		
Home Address ☐ Same as Child's			Home Telephone Number ☐ Same as Child's		
City			State		Zip
Email Address (if applicable)			Cell Phone		
Parent's Work/School Name			Parent's Work/School Telephone Number		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. ☐ Yes ☐ No					
If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email					
Where can you be reached while your child is in this program/home?					
Emergency Contacts: Parents cannot be listed as emergency contacts. List the name of <u>at least one person</u> who can be contacted in the event of an emergency or illness if you cannot be reached . Any person listed should be able to assist in contacting you. At least one person listed must be able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.					
Name			Name		
City		State	City		State
Telephone Number		Relationship to Child	Telephone Number		Relationship to Child
Other numbers where emergency contact can be reached (if applicable)			Other numbers where emergency contact can be reached (if applicable)		
Name of Physician or Clinic/Hospital					
Street Address					
City		State	Telephone Number		

Child's Name

Allergies, Special Health or Medical Conditions, and Medical Foods

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - *check all that apply* ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on file.

☐ N/A - program does not provide meals or snacks to the child.

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff or medical personnel in an emergency situation.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

☐ Not applicable

Child's Name

Diapering Statement

Is your child toilet trained? ☐ Yes (If yes, skip to Emergency Transportation Authorization section)

☐ No (If no, fill out the following:)

The program's policy is to check diapers every ____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every ____ hours.

Emergency Transportation Authorization

Give <u>Permission</u> to Transport		OR Do not sign both	<u>Do Not Give Permission</u> to Transport	
Program or Home Name			Program or Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.			does not have permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date		Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☐ Yes ☐ No (check one)

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)

Date

Administrator/Designee Signature

Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note:

This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15, 5101:2-13-15, and 5101:2-14-04. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Ohio Department of Job and Family Services
FAMILY INFORMATION
FOR STEP UP TO QUALITY PROGRAMS (SUTQ)

Child's Name (Last)	(First)	Nickname (if any)
<i>By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.</i>		
Who is in the child's immediate family?		
Who lives at home with your child?		
What is the primary language spoken in your child's home?		
Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? Additional Details?		
Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet) Additional Details?		
Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, head coverings, etc.)		
Do you have any pets at home? If so, what are they and what are their names?		
Has your child had a previous care arrangement? ☐ Yes or ☐ No Additional Details? (Center based, in home, with family, with parents, etc.)		
My child drinks ☐ milk, ☐ formula, ☐ juice or ☐ water. (Check all that apply) How much and how often?		
Does your child have any favorite foods?		
Does your child dislike any foods?		
Are there any foods your child should not be fed? (Licensing requires documentation be completed for children with food allergies and/or dietary restrictions)		

Please check all of the words that best describe your child's personality and behavior

- ☐ active ☐ adventurous ☐ affectionate ☐ anxious ☐ bossy ☐ bright ☐ busy ☐ calm ☐ cautious ☐ cheerful
☐ content ☐ creative ☐ curious ☐ easily-angered ☐ emotional ☐ energetic ☐ excitable ☐ friendly ☐ gives-in-easily
☐ happy ☐ hesitant ☐ insecure ☐ jealous ☐ likes structure/routines ☐ loud ☐ loving ☐ mellow ☐ outgoing
☐ prefers adult attention ☐ quiet ☐ sensitive ☐ serious ☐ shares-well ☐ social ☐ spontaneous ☐ stubborn ☐ tentative
☐ other:

Are there additional personality and behavior characteristics that would be useful to know about your child?

Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?

What routines/actions or items do you use to comfort your child?

What causes your child to feel angry or frustrated?

What methods do you use to respond to your child's negative behavior?

Does your child use any special comfort or support items that help him/her go to sleep? If so, what?

What is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken)?

My child sits in a ☐ high chair, ☐ booster, ☐ child size chair or ☐ adult size chair. (Check the one that applies.)

Is your child toilet trained? If not, have you started the toilet training process? Please explain the process used.

Does your child need assistance when using the toilet? If so, how?

What words, gestures or signs does your child use if he/she needs to use the bathroom?

What time does your child normally go to bed at night and wake up in the morning?

What time(s), and for how long, does your child usually nap?

Does your child have trouble sleeping (Night terrors, trouble going to sleep, etc.)? Please explain.	
What might you and/or your child be anxious about as he/she starts in this program?	
What are you and/or your child excited about as he/she starts in this program?	
What are your expectations of this program?	
What other information would be helpful for the staff caring for your child to know?	
Parent/Guardian's Signature	Date

Ohio Department of Children and Youth
FAMILY NEEDS SURVEY FOR STEP UP TO QUALITY (SUTQ)

We want to support any needs you or your family may have. THE INFORMATION YOU PROVIDE ON THIS FORM IS CONFIDENTIAL Please circle Y (YES) or N (NO) to best describe your current situation for each topic. If you circle Y for an item, please briefly list the CONCERN if this is an area of need for your child or family. Our goal is to provide resources to support you and your family, based on your answers.		
Child's/Children's Name(s):	Caretaker's Name:	
Date Completed:		
TOPICS		
Briefly List CONCERN		
Child Development and Education- Does anyone in your family have any need for resources or support in the areas listed below?		
Y	N	Information on child growth and development.
Y	N	Guiding and supporting a child's behavior.
Y	N	Medical or disabilities or possible conditions for any child or adult in the family.
Y	N	Obtaining toys or activities to use to help any child in your home.
Y	N	Preparing your child for kindergarten.
Child and Family Health- Does anyone in your family have any need for resources or support in the areas listed below?		
Y	N	Health insurance and/or access to regular medical care, dental care, or medications.
Y	N	Medical or health supplies or supports that anyone in your family needs.
Y	N	Accessing immunizations.
Y	N	Finding a pediatrician, general practitioner, dentist, therapist, psychologist, optometrist, or other specialty practitioner.
Y	N	Concerns with depression, anger, anxiety, or mental health needs.
Y	N	Concerns with alcohol, drug, or addiction problems.
Financial and Household Supports- Does anyone in your family have any need for resources or support in the areas listed below?		
Y	N	Help paying for child care.
Y	N	Help finding housing or safe housing.
Y	N	Help paying your mortgage or rent.
Y	N	Help with food expenses.
Y	N	Finding household items such as furniture, clothing, or school supplies.
Y	N	Access to transportation or transportation expenses.
Y	N	Attending school (such as a GED, Certifications, or college degrees)
Y	N	Help finding work or job training

Are there other needs you or your family have that are not listed above:	
Parent Signature	Date:
Administrator or Designee Signature:	Date:

For Staff Use:

Bronze Rating Level	Silver Rating Level	Gold Rating Level
Resources provided to the family:	Resources provided to the family:	Resources provided to the family:
Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:
Referrals provided to the family:	Referrals provided to the family:	Referrals provided to the family:
Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:
Follow-up provided to the family:		Follow-up provided to the family:
Administrator or Designee Signature & Date:		Administrator or Designee Signature & Date:



PARENT REGISTRATION

HOW DO I SIGN UP?

1. Go to <https://mohawk-oh.finalforms.com>
2. Click **NEW ACCOUNT** under the Parent Icon



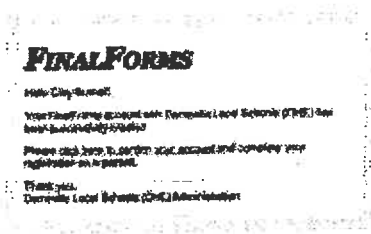
Parent



3. Type your NAME, DATE OF BIRTH and

EMAIL, then click **REGISTER**

4. Check your Email for a FinalForms Email and click **CONFIRM YOUR ACCOUNT** in the email text.



NOTE: You will receive an email within 2 minutes

prompting you to confirm and complete your

registration. If you do not receive an email, check your

spam folder. If you still do not see the FinalForms

email, please email support@finalforms.com

5. Create your new FinalForms password and click **CONFIRM ACCOUNT**

You're almost done registering
as a Parent

Now we need you to create a new password for your account.

New Password:

Confirm Password:

Confirm Account

6. You may be asked if you want to grant another Parent/Guardian access to your registered students. Either click **SKIP THIS STEP** or type the NAME, DATE OF BIRTH and EMAIL, then click **ADD PARENT ACCOUNT**.

Add Another Parent? ☐ Skip this step

If you choose to add another parent, please enter the parent's name, date of birth, and email address.

Name:

Date of Birth:

Month:

Day:

Year:

Add Parent Account

7. Your account(s) will be created, you can then click **REGISTER STUDENT** for your first child.

FINAL FORMS™

REGISTERING A STUDENT

WHAT INFO WILL I NEED?

- Basic Medical History & Health Info
- Doctor, Dentist & Hospital Information
- Insurance Company & Policy Number
- Email Address for BOTH you and your student (if required by your district)

HOW DO I REGISTER MY FIRST STUDENT?

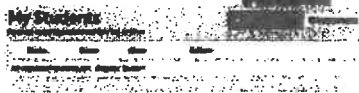
*****IMPORTANT***** If you have followed the steps on the *previous page, you may Jump to Step 3.*

1. Go to <https://mohawk-oh.finalforms.com>
2. Click **LOGIN** under the Parent Icon



Parent

3. Click **REGISTER STUDENT**



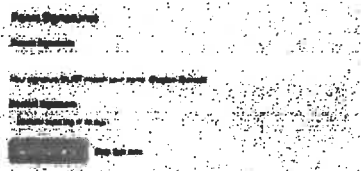
4. Complete the form including the Student's Legal Name, **EMAIL ADDRESS**, Date of Birth, Gender, Graduation Year, Home Address and any other information required by your School District, then click **CREATE STUDENT**

NOTE: A student email address may or may not be required depending on your school district preferences. If so, the email address provided may be used to send reminders to your student.

5. If your student plans to participate in a sport, activity, or club please click the checkbox for each. Click **UPDATE** after making your selection.

NOTE: A selection can be changed any time until the registration deadline.

6. Complete each form and sign your full name (e.g. "John Smith") into the Parent Signature field at the bottom of the page. After signing, click **SUBMIT FORM** and move on to the next form.



7. When all forms are complete, you will see a "Forms Finished" message.

*****IMPORTANT***** If required, an email will automatically be sent to the email address that you provided for your student prompting him/her to sign Student forms requiring his/her signature.

8. Click **MY STUDENTS** if you are done or **REGISTER ANOTHER STUDENT** if you need to add another.
9. At any point in the future, you may login at any time and click the **UPDATE FORMS** button