



Ohio Valley ESC
Bright Beginnings Preschool

NEW student

Enrollment Application

2026-2027 School Year



We are excited to learn with you!

This packet must be completed and all documentation submitted as soon as possible for your child to be considered for a classroom spot.

Questions?

email: joy.edgell@ovesc.org

Thank you for letting us serve your family!

★ Application will require extra postage - please use 3 stamps when mailing.

Information:

Thank you for your interest in the Ohio Valley Educational Service Center's Bright Beginnings Preschool for students ages 3 through 5 years old. Children are placed in classes **once ALL required paperwork and documents are submitted.** We place returning students first within the school district of residence, then we place by age of the child (older children are placed first), and last we place by the date of the returned, completed application. We look forward to working with your family!

COST:

Bright Beginnings Preschool offers payment options based upon income and the number of days your child attends class per week/month. **The tuition is a flat rate and refunds are NOT given for absences, holidays and/or calamity days.** The maximum tuition rate possible is \$150.00 for full time enrollment per month. Tuition assistance may be available upon completion of the enrollment application and submission of required proof of income documents. Tuition is due prior to starting preschool and is due on the first day of each month. May's tuition is due April 15. Tuition may be paid at either OVESC office (Cambridge or Marietta), through USPS mail, or online at www.ovesc.org

REQUIRED DOCUMENTS FOR ADMISSION for ALL NEW STUDENTS:

- Enrollment Application (with ALL SECTIONS completed, including the child care assistance pages)
- Child Care Assistance application filled in and (SNAP, MEDICAID, tax return-if self-employed)
- Proof of Income (4 pay stubs from most current employer for each working person in the home)
- Birth certificate (the actual copy, we can not accept the crib sheet from the hospital)
- Custody Papers (if applicable)
- Proof of Residency (a copy of a utility bill)
- Immunization Records

**We also require a Valid EMAIL ADDRESS*

→ *Please make sure to sign every signature line with an arrow beside it*

****ALL REQUIRED INFORMATION IS MANDATORY to secure your child's spot in a preschool classroom.**
Once our Marietta office receives your completed packet, we will notify you if there is an opening for your child.

Medical and Dental Forms(to be completed by a medical professional):

- Students have 30 days from classroom start date to submit both documents
- New forms must be submitted yearly (within 13 months of last visit due to insurance reasons)

MAIL TO:

OVESC BRIGHT BEGINNINGS PRESCHOOL

Broughtons Complex 3 - Building 16B

2333-B St. Rt 821

Marietta, Ohio 45750



Enrollment Application 2026-2027

My child is a RETURNING STUDENT or NEW STUDENT (please circle one)

CHILD'S NAME: (Please PRINT entire application)

First:	Middle:	Last:
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Child's Information:

Date of Birth:	Gender (please circle): Male Female
Foster Child: Yes No	Primary Language Spoken at Home:
Birthplace City:	County of residence:
Mother's Maiden Name:	
Does your child have an IEP? YES or NO	
IN PROCESS OF IEP? YES or NO	Did your child attend Bright Beginnings Preschool previous school year? : Yes No

Racial Group/Local Ethnic Category: (check all that apply)

☐ Asian ☐ Black/African American ☐ Hispanic
☐ American Indian/Alaska Native ☐ Multi-Racial
☐ White ☐ Native Hawaiian or Other Pacific Islander

Hispanic/Latino: Yes No

Is the parent an OVESC employee? Yes No

Who Child Lives with/Residential Parent is: (circle all that apply): Mother Father Other

Father's Name:	Mother's Name:
Father's Address:	Mother's Address:
City, State and zip	City, State, and zip
Father's Home #:	Mother's Home #:
Father's Cell #:	Mother's Cell #:
Father's Work #:	Mother's Work #:
Father's Email (must have):	Mother's Email (must have):
School District of Residence:	School District of Residence:

Preferred Location – Please mark - 1st choice, 2nd choice, 3rd choice (Listed by District/School):

☐ Belpre- Belpre ☐ Fort Frye - Lowell ☐ Fort Frye - Beverly-Center ☐ Frontier - Newport ☐ Marietta - Phillips (includes former Ewing) ☐ Marietta -Washington (includes former Ewing) ☐ Crooksville ☐ Rolling Hills - Brook Admin and Early Learning Center	☐ Switzerland of Ohio - Beallsville ☐ Switzerland of Ohio - Powhatan ☐ Switzerland of Ohio - River ☐ Switzerland of Ohio - Skyvue ☐ Switzerland of Ohio - Woodsfield ☐ Switzerland of Ohio - Monroe DD ☐ Warren - Warren ☐ Wolf Creek - Waterford
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Office Use Only	Start Date:	SSID #:
Dis. Condition:	Services:	Preschool:
Teacher:	Poverty Level:	Typical
IEP / Itinerant:	By:	Entered EMIS ✓:

ENROLLMENT PACKET

Child History:		
Did mother have any unusual physical/emotional illness during pregnancy? ☐ Yes ☐ No		
If Yes, Please explain:		
Age of mother when child was born:	Child's Birth Weight:	
Child was: (please check) ☐ Full Term ☐ Early ☐ Late If applicable how early/late?		
Did the child have any sickness/problems? ☐ Yes ☐ No If Yes, Please explain:		
Please indicate at what age the child began the following activities:		
Walked alone _____	Was Toilet Trained _____	
Spoke in Sentences _____	Dressed Self _____	
How does this child's development compare to other children (siblings or playmates)?		
(please check) ☐ About the same as others ☐ Slower than others ☐ Faster than others		
Please list/describe allergies (to medications, foods, plants, animals) and reactions to these items:		
Please list/describe recommended treatment to these reactions:		
Please list any severe injuries, illnesses, surgeries you child has had:		
Injury/Illness/Surgery	Was the child hospitalized?	Age at time of event?
1.		
2.		
3.		
Please describe any medications, food supplements, modified diet or fluoride supplements, the child takes daily and/or frequently:		
Medication/Supplements	Reason taken?	How often?
1.		
Please check ☒ any health conditions the child has/had:		
☐ Abnormal spinal curvature ☐ Allergies/hay fever ☐ Anemia ☐ Anaphylactic reaction ☐ Asthma or wheezing ☐ Attention Deficit Disorder ☐ Behavior problems ☐ Birth/Congenital malformation ☐ Cancer - Type _____ ☐ Chicken pox - date _____ ☐ Chronic diarrhea/constipation ☐ Chronic ear infections ☐ Concern about relationships ☐ Cystic Fibrosis ☐ Diabetes ☐ Eczema/Chronic skin condition ☐ Emotional problems ☐ Eye problems or poor vision ☐ Frequent headaches ☐ Frequent sore throats	☐ Heart disease - type _____ ☐ Hemophilia ☐ Hepatitis ☐ Hyperactivity ☐ Kidney disease - type _____ ☐ Measles ☐ Meningitis or Encephalitis ☐ Mumps ☐ Near-drowning/near suffocation ☐ Nervous twitches or tics ☐ Poisoning ☐ Rheumatic fever ☐ Seizure disorder/epilepsy ☐ Sickle cell disease ☐ Speech difficulties ☐ Stool soiling ☐ Toothaches/dental problems ☐ Urinary tract infections ☐ Wetting during day or night ☐ Other _____	

PARENT INITIALS _____

ENROLLMENT PACKET

Emergency Contacts: Please list 3 people to be contacted in the event of an emergency IF the parent cannot be contacted.								
Contact #1:			Contact #2:			Contact #3:		
Street Address			Street Address			Street Address		
City State Zip			City State Zip			City State Zip		
Relationship to Child:			Relationship to Child:			Relationship to Child:		
Phone #			Phone #			Phone #		
Cell #			Cell #			Cell #		
Work #			Work #			Work #		

Child's Name: First Middle Last		
Authorization to Release Child: My child may be released to his/her parent/guardian AND the following people only (without prior written authorization).		
Name	Relationship to Child	Phone #
My child may <u>NOT</u> be released to the following individuals: Please attach a copy of divorce decree and/or restraining order if applicable.		
Name	Relationship to Child	Please note any special circumstances of which the staff should be aware:

Please indicate if the family is involved with any of the following community services:	
Speech Therapy: ☐ Yes ☐ No If yes, where?	Head Start/Early Head Start: ☐ Yes ☐ No
Occupational Therapy: ☐ Yes ☐ No If yes, where?	Help Me Grow/Early Intervention: ☐ Yes ☐ No
Physical Therapy: ☐ Yes ☐ No If yes, where?	Job & Family Services: ☐ Yes ☐ No If yes, caseworker?
Hearing Services: ☐ Yes ☐ No If yes, where?	Child/Protective Services: ☐ Yes ☐ No If yes, caseworker?
Vision Services: ☐ Yes ☐ No If yes, where?	Preschool/Day Care: ☐ Yes ☐ No If yes, where?
Mental Health/Individual/Family Counseling Services: ☐ Yes ☐ No If yes, where?	
MUST HAVE A PHYSICIAN/DENTIST LISTED:	
Physician's Name:	Dentist's Name:
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code
Phone #	Phone #
Fax #	Fax #

PARENT INITIALS _____

ENROLLMENT PACKET

Things I would like my child's preschool teacher to know:	
My child is: ☐ very active ☐ normally active ☐ not very active	
My child prefers playing: ☐ alone ☐ with other children	
My child has become violent or acted out in the following manner towards other children or adults. (please check all that apply) ☐ Hitting ☐ Kicking ☐ Biting ☐ Fighting ☐ Scratching ☐ My child has never become violent or acted out toward others.	
If my child becomes upset, they calm themselves by: _____	
I have concerns about how my child gets along with other children. ☐ Yes ☐ No If yes, please explain: _____	
My child's favorite color is: _____	My child's favorite book is: _____
My child's favorite food is: _____	My child's favorite toy is: _____
My child likes to: ☐ Listen to stories ☐ Play inside ☐ Play outside ☐ Draw/Color ☐ Play quiet games ☐ Play pretend/make believe ☐ Other _____	
I would like for my child to be able to: _____	
Please add any comments or concerns that you have about your child's health, development, behavior, family or home life that you would like the school to be aware of. _____ _____ _____	

Authorization for School District Transportation: Please initial on the appropriate line below.
☐ Yes, I grant permission for my child to be transported to/from school and/or field trips by the school district bus/van, if appropriate.
☐ Yes, I grant permission for my child to participate in walking field trips that are close to my child's school.
☐ No, I DO NOT grant permission for my child to be transported to/from school and/or field trips by the school district bus/van, if appropriate.
☐ No, I DO NOT grant permission for my child to participate in walking field trips that are close to my child's school.

Authorization for Annual Class Roster: Each year we prepare a roster for each group of children in our program. This roster will not be shared with any person other than the parents of children enrolled in our program.	
I authorize the following information to be listed on the Class Roster (please check):	
My Child's Name: ☐ Yes ☐ No	Parent/Guardian Home Phone Number ☐ Yes ☐ No
Parent/Guardian Name: ☐ Yes ☐ No	Parent/Guardian Cell Phone Number ☐ Yes ☐ No

PARENT INITIALS _____

ENROLLMENT PACKET

Authorization for Picture Publication: Please initial on the appropriate line below.

____ Yes, I grant permission for my child to have his/her picture taken for possible publication (newspaper, brochure, website, or other social media etc.) Furthermore, I grant permission for my child to be videotaped and understand that it may be used for professional development and/or advertising purposes.

____ No, I DO NOT grant permission for my child to have his/her picture taken for possible publication (newspaper, brochure, website, etc.) Furthermore, I DO NOT grant permission for my child to be videotaped and understand that it may be used for professional development and/or advertising purposes.

As the parent/guardian of _____, I authorize the information as listed above
(Authorization to Release Child, Authorization for School District Transportation, Authorization for Annual Class Roster, and Authorization for Picture Publication).

→ _____
Parent/Guardian Printed Name

→ _____
Parent/Guardian Signature Date

Authorization for Participation and Release of Information:

My child has permission to participate in any health/developmental/academic screenings and assessments (which may include, but are not limited to physical, dental, vision, hearing, speech, mental health, lead, iron, height, weight, developmental, etc.) that are conducted through the Ohio Valley Educational Service Center, Bright Beginnings Preschool and other community agencies.

The Ohio Valley Educational Service Center has my permission to conduct assessments as required by the Ohio Department of Education (which may include, but are not limited to the Early Learning Assessment, Child Outcomes Summary Process, etc.) I understand that my child's teacher/specialist will provide feedback regarding the assessment to myself and other staff members working with my child. Additionally, I grant permission for the preschool administration to report the results of these assessments electronically, as required by law, to the Ohio Department of Education.

I understand that there may be some screenings/assessments that are not able to be conducted at my child's preschool setting and that I may need to obtain these screenings/assessments through my child's physician, dentist, local health department or other community agencies. I also understand that it may be necessary to obtain follow-up care for my child based on the results of the health/developmental assessments performed and that it will be my responsibility to do so.

The Ohio Valley Educational Service Center has my permission to share my child's information with all agencies that fall under the Department of Children and Youth as required by law, specifically the county office of Jobs and Family Services. This information may include any part of your child's enrollment application and/or proof of income.

As the parent/guardian of _____, by signing, I am verifying that I have read, understand and agree with the above information.

→ _____
Parent/Guardian Printed Name Parent/Guardian Signature Date

PARENT INITIALS _____

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
2026 FEDERAL POVERTY GUIDELINES
OHIO VALLEY EDUCATIONAL SERVICE CENTER
2333-B State Route 821, Complex 3, Bldg 16B, Marietta, OH 45750 / 740-373-6669

OFFICE USE ONLY

Size of Family Unit	Monthly Income	Monthly Income	Monthly Income	Monthly Income
2	\$2,615.00	\$2,705.00	\$3,607.00	\$5,410.00
3	\$3,302.00	\$3,415.00	\$4,554.00	\$6,830.00
4	\$3,988.00	\$4,125.00	\$5,500.00	\$8,250.00
5	\$4,674.00	\$4,835.00	\$6,447.00	\$9,670.00
6	\$5,361.00	\$5,545.00	\$7,394.00	\$11,090.00
7	\$6,047.00	\$6,255.00	\$8,340.00	\$12,510.00
8	\$6,733.00	\$6,965.00	\$9,287.00	\$13,930.00

Parents: Due to state reporting requirements, we are required to gather income information for your family. This information in no way will be used to determine if your child qualifies for services and/or what services your child will receive. Simply find the number of family members that are in your household, and determine the dollar amount that is closest to your family's gross monthly income. Please circle the dollar amount in that particular row that most closely reflects the gross income for your family.

If you have any questions, please contact the OVESC office at 740-373-6669.

MUST submit for Placement: Please provide **ONE** of the following types of proof of income. Thank you.

- *4 most recent pay stubs for each working person in home OR
- *A statement from Ohio Department of Job & Family Services caseworker stating your poverty level OR
- *A copy of your most recent tax return showing gross income (if self-employed) OR
- *SNAP or Medical Card approval letter

_____ Parent/Guardian Signature

*complete highlighted sections

Ohio Department of Job and Family Services
Publicly Funded Child Care Release of Information

Caretaker Name		Phone Number													
Street Address		City	State Zip												
Caretaker Email (must be email you used in the SSP, if you have an SSP account)		Last four digits of Caretaker SSN													
REASON FOR THE CONSENT TO RELEASE INFORMATION This consent gives permission for the county department of job and family services (CDJFS)/Ohio Department of Job and Family Services (ODJFS) to release publicly funded child care application information to the identified child care provider. You are not required to complete this form to be eligible for publicly funded child care. A child care provider cannot require you to complete this form as part of their enrollment process and/or to receive child care.															
CONSENT TO RELEASE INFORMATION															
<u>Reason for Consent</u> I understand that by signing this that the provider(s) has access to my information until the access is revoked by me or my authorized representative even if I'm no longer attending that program. • Primary caretaker first and last name, address and phone number • First and last name and date of birth of children needing care. • Application information: ○ Application status, including denied without PAD (payment after denial) and pending application. ○ Verification documents needed. ○ Eligibility begin and end date. ○ Authorization information															
This information may be released to: <table border="0"> <tr> <td>Provider 1 name</td> <td>OVESC</td> <td>Provider 2 name</td> <td></td> </tr> <tr> <td>Program license number</td> <td></td> <td>Program license number</td> <td></td> </tr> <tr> <td>Provider address</td> <td>Broughton Complex 3 Building 14B 3330 St. Rt 821 Marengo, OH 4530</td> <td>Provider address</td> <td></td> </tr> </table>				Provider 1 name	OVESC	Provider 2 name		Program license number		Program license number		Provider address	Broughton Complex 3 Building 14B 3330 St. Rt 821 Marengo, OH 4530	Provider address	
Provider 1 name	OVESC	Provider 2 name													
Program license number		Program license number													
Provider address	Broughton Complex 3 Building 14B 3330 St. Rt 821 Marengo, OH 4530	Provider address													
• This document can be submitted using one of the following methods: 1. Uploaded into the Self-Service Portal (SSP) by accessing your benefit http://sssp.benefits.ohio.gov/ 2. Submitted to the caretakers' county agency. • This consent will remain in effect for eighteen months from the date of application for pending and denied child care applications or may be revoked by the Caretaker or Caretaker's Authorized Representative at any time by providing notice in writing, which must include your name and case number using one of the following: • Uploaded into the Self-Service Portal (SSP) by accessing your benefit http://sssp.benefits.ohio.gov/ • Submitted to the caretakers' county agency. • By signing this form, I am responsible for terminating the listed provider(s) access to the information listed on this form. • Be aware that the information used or disclosed pursuant to this authorization may be disclosed by the recipient of the information and may no longer be protected from disclosure. • Treatment, payment, enrollment, or eligibility for public assistance cannot be conditioned on signing this authorization unless the authorization is necessary for determining eligibility for the public assistance program. • Pursuant to federal and state law, and applicable policies the ODJFS may access and disclose information contained in systems controlled or maintained by the ODJFS or controlled and maintained for the benefit of the ODJFS.															
Signature of Caretaker or Caretaker's Authorized Representative listed in Ohio Benefits			Date												

Early Childhood Education Grant Zero Income and McKinney-Vento Statement

Families with no income must provide a written explanation of how they are meeting basic living expenses, including food, housing/shelter, utilities and transportation.

The McKinney-Vento Act provides resources for children of families that are experiencing homelessness. Preschool students experiencing homelessness are eligible for immediate enrollment in programs with Title 1 funding. Homelessness is defined as:

Individuals who lack a fixed, regular, or adequate nighttime residence and includes:

- 1. Children who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals;*
- 2. Children who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation;*
- 3. Children who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and*
- 4. Migratory children who qualify as homeless because they are living in circumstances described in 1-3 above.*

I, _____, verify that neither I nor any member of my family earns/receives any income.

I, _____, verify that my family meets the definition of homelessness.

Briefly describe how your family is meeting food, housing, utilities and transportation needs:

I certify that the information above is complete and accurate to the best of my knowledge. I understand that if I knowingly give false information or misrepresentation of my income, it may result in disqualification.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

Witness Printed Name: Joy Edgell

Witness Signature: [Signature] Date: 8/1/20

INCOME/and ASSISTANCE FORM

MUST be filled in for your child's application to be COMPLETE:

Please check if you receive:

- ☐ SNAP
- ☐ Medical Card
- ☐ Cash Assistance

If you marked yes - please submit a copy of your APPROVAL letter with this application

EVERYONE MUST provide **ONE** of the following with this application for the application to be processed.

- ☐ SNAP, medical card or cash assistance approval letter
- ☐ A copy of your most recent tax form, showing gross income
(tax return only if self-employed)
- ☐ 4 most recent pay stubs for each person working in the home

****You may be contacted later to provide additional income statements****

The following CHILD CARE ASSISTANCE form **must be completed** by every family. You only need to complete the circled/HIGHLIGHTED sections and ensure your signature is at the end of the form.

This information is kept confidential.

2026-2027 Bright Beginnings Preschool Tuition Rates

Please read & initial below

All Washington County Districts (Fort Frye, Frontier, Belpre, Marietta, Warren, Wolf Creek) - \$150.00/month

Crooksville- \$150.00/month

Federal Hocking- \$150.00/month

Rolling Hills- \$150.00/month

Switzerland- Free to families who reside within Switzerland of Ohio School District, otherwise \$150.00/month.

****Bright Beginnings Preschool offers tuition reduction options based upon income. Tuition assistance may be available upon completion of the enrollment application and submission of required proof of income documents. ****

Parent Initials: _____

Early Care and Education Services Selection

I _____ am applying **ONLY** for the Ohio
(Print First and Last Name)

Preschool Program (OPP) for the following children:

NAME	DATE OF BIRTH	PROGRAM LICENSE NUMBER
↑ Office will complete ↑		

Acknowledgment: By signing below, I confirm that:

- I am requesting eligibility for OPP-only be explored.
- I understand that this application does **not** serve as an application for Publicly Funded Child Care (PFCC).
- If I later choose to apply for PFCC, I will submit a new application.

Parent/Guardian Signature: _____

Date: _____

SNAP, CASH, MEDICAL, AND/OR ECE ASSISTANCE APPLICATION

Voter Registration Application Attached - Assistance Available

If you are **NOT** registered to vote where you live now, would you like to apply to register to vote here today?

- ☐ Yes - I want to register to vote.
- ☐ No - I do **NOT** want to register to vote.

If you do not check either box, you will be considered to have decided not to register to vote at this time. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

Step 1: Check the box for each program the applicant wants to apply for

You can apply for any and all of the programs listed below. If you do not check any boxes, we will only review your eligibility for SNAP.

- ☒ ~~SNAP~~ ☐ ~~Cash Assistance~~ - For families with a minor child(ren) or women who are pregnant ☐ ~~Refugee Cash Assistance (RCA)~~ - For refugees within 4 months of arrival
- ☐ ~~Medical Assistance~~ ☒ **OPP** - Preschool for ages 3 to kindergarten eligible ☐ ~~PFCG/ECVP~~ - Child Care for families working in school/training

Step 2: Tell us about the applicant

If you are an Authorized Representative, enter information about the person you are applying for.

First Name

Middle Initial

Last Name

Do you need any of the following services?

- ☐ Large Print Notices ☐ Sign Language Interpreter
- ☐ Translator ☐ Other _____

What is your preferred language?

Spoken: _____

Written: _____

Have you, or anyone living with you, ever received SNAP, Cash, Medical, or ECE Assistance?

- ☐ No Location (City/County/State): _____
- ☐ Yes - If yes, who: _____

Step 3: Tell us how to reach the applicant

If you are an Authorized Representative, enter information about the person you are applying for.

Home Address ☐ Check here if you do not have a permanent address - please provide a mailing address

City

State

Zip Code

Phone (Cell)

Phone (Home)

Email Address

Address where you get mail (if different)

City

County

State

Zip Code



Reminder: Did you tell us which program(s) the applicant is applying for?
Make sure to check the appropriate box(es) in Step 1.

Step 4: Tell us if you are an Authorized Representative

An Authorized Representative is someone who helps the applicant with the application process and can act on the applicant's behalf. If you are filling out this form as an Authorized Representative, please give us the following information about yourself. The applicant may be asked to give an authorization document. You will not be listed as an Authorized Representative until the document is provided.

First Name	Middle Initial	Last Name
Street Address		
City	State	Zip Code
Phone (Cell)	Phone (Home)	
Email Address		
Do you need any of the following services? ☐ Large Print Notices ☐ Sign Language Interpreter ☐ Translator ☐ Other _____		What is your preferred language? Spoken: _____ Written: _____

Step 5. For SNAP Applicants and SNAP Authorized Representatives ONLY

By signing below, you agree that you have **reviewed and agree to the terms in Step 14** and you certify, under penalty of perjury, the truth of the information contained in this application, including information provided below concerning citizenship and qualified non-citizen status of the members applying for benefits.

While you may submit your application with only the information provided above, your application may be processed more quickly if you continue to provide responses to the questions below.

 Signature of Applicant OR Authorized Representative	Date
Print Name of Applicant OR Authorized Representative	Date

Step 6: Answer the following ONLY if applying for SNAP benefits

How many people live with you and buy, fix, and eat meals with you? _____

This number is considered your **"household"**, keep this in mind when answering the next two questions.

Note: Your responses will help us decide if you can get SNAP more quickly. If someone else you live with is already receiving SNAP benefits, you may still be eligible for SNAP benefits.

Is your household's total gross income before taxes for the current month less than \$150? ☐ Yes ☐ No

Is your household's total net income for the current month zero after taxes and paying for such things as housing costs, child/dependent care costs, or child support payments?

☐ Yes ☐ No

Are your total resources in cash, checking, and savings accounts \$100 or less?

☐ Yes ☐ No

Are your monthly rent or mortgage and utilities (such as gas, electric, water, and phone) more than your total monthly gross income before taxes?

☐ Yes ☐ No

Are you a migrant or seasonal farm worker?

☐ Yes ☐ No

Step 7: Tell us the applicant's information

You must list everyone who lives with you even if they are not applying. Please be sure to list your name first. If you need more space, write your answers on an extra piece of paper and attach it to this form. **Please use the following to assist with completing the section below:**

- **Social Security Number (SSN):** If you, or anyone else in your household, is NOT a U.S. citizen, or a Qualified Non-Citizen, you do not have to give us an SSN. If there are other reasons that you, or someone in your household does not have an SSN, please write that below (ex: pending SSA application).
- **U.S. Citizen:** You only have to tell us if someone is a U.S. citizen if they are applying for SNAP, Cash, Medical, or ECE Assistance.
- **Race/Ethnicity:** Title VI of the Civil Rights Act of 1964 allows us to ask for racial/ethnic (Hispanic or Latino) information. Providing this information is voluntary and is used for informational purposes only. If you do not want to give us this information, it will have no effect on your case.

All info for everyone in the home

Name	Relationship to You (spouse, friend, etc.)	SSN (See instructions above)	Date of Birth	Sex	U.S. Citizen	Hispanic or Latino	Race
	Self			☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N	
				☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N	
				☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N	
				☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N	
				☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N	

Are you married? ☐ No ☐ Yes - If yes, spouse's name: _____

Are you, or anyone you are applying for, pregnant?

☐ No ☐ Yes - If yes, who and when is the due date? _____

Do you, or anyone you are applying for need in-home care or nursing home services?

☐ No ☐ Yes - If yes, who? _____

Are you or anyone in your household caring for a disabled person in or outside of the home?

☐ No ☐ Yes - If yes, who? _____

Are you or anyone in your household in the military?

☐ No ☐ Yes - If yes, please select all that apply: ☐ Active Duty ☐ National Guard/Reserves

Have you ever been found guilty of Child Care fraud? ☐ No ☐ Yes

Step 8: Household members 60 years of age or older

Is anyone 60 years of age or older?

☐ No - If no, please skip to Step 9. ☐ Yes - If yes, answer the following questions in Step 8.

Is this person(s) receiving disability benefits?

☐ No ☐ Yes - If yes, from what source? _____

Is this person(s) unable to prepare meals due to a disability?

No Yes

If you answered "Yes" to all three questions in Step 8, does this person(s) want to receive SNAP separately from the other people you live with?

No Yes

Step 9: Tell us about the household's finances

Have you or the people in your household received, or expect to receive, income* this month?

☐ No ☐ Yes - If yes, please complete the table below.

*Income refers to all the money that you and the people in your home receive. This includes earnings from employment or self-employment, child or spousal support, disability benefits, retirement benefits, Workers' Compensation, Unemployment Compensation, Social Security, SSI, Veterans' Benefits, Ohio Works First (OWF), gifts of money from individuals, etc.

Name	Type of Income or Name of Employer	How Often Received (weekly, bi-weekly, etc.)	Income Amount (before taxes)	Date Last Received

How much do you and the people in your household have in cash, checking, or savings (such as bank accounts, annuities, stocks, or bonds)?

Give your best estimate of the total amount: \$ _____

Do you and the people in your household have more than one million total dollars in cash, checking, or savings (such as bank accounts, annuities, stocks, or bonds)?

☐ No ☐ Yes

Did anyone in your household leave a job or lose a job within the last 60 days?

☐ No ☐ Yes - If yes, who? _____
When? _____
For what reason? _____

Is anyone in your household on strike from a job?

☐ No ☐ Yes - If yes, who? _____

This Form Continues on the Next Page



Step 10: Tell us about the applicant's household expenses

Check all that apply. List the amount for each expense.

- ☐ **Child/Dependent Care Costs:**
Estimated Amount Paid per Month: \$ _____
- ☐ **Child or Spousal Support Payments Made to Someone Outside Your Household**
Estimated Amount Paid per Month: \$ _____
- ☐ **Medical Expenses for Anyone Who is Disabled or Age 60 or Older.** These include expenses such as medical bills, prescriptions, health insurance premiums, transportation to medical appointments, or other medical services.
Estimated Amount Paid per Month: \$ _____
- ☐ **Rent, Mortgage Payments, Lot Rent, Property Taxes, Homeowners' Insurance, etc.**
Estimated Amount Paid per Month: \$ _____

Do you or anyone in household pay for heat or air conditioning?

☐ Yes

☐ No

(check all that apply):

☐ Telephone

☐ Trash

☐ Sewage

☐ Water

☐ Electric

☐ Gas

Step 11: If applying for Early Care and Education assistance, please tell us why the applicant needs Early Care and Education assistance

* Parent

If you or the people in your home are working, attending school, participating in a training program (e.g. CDL, STNA, Barber or Cosmetology) or are participating in a Substance Use Disorder program (inpatient, outpatient, AA/NA or counseling for substance use), **please complete the table below with all qualifying activities. If you need more space, write your answers on an extra piece of paper and attach it to this form.**

Household Member 1 Name

Employer / School / Training Information Name

Activity Phone Number

Start Date / End Date

Address

Household Member Work / School / Training Schedule- Include travel time needed

☐ Sun From _____ to _____

☐ Thurs From _____ to _____

☐ Mon From _____ to _____

☐ Fri From _____ to _____

☐ Tues From _____ to _____

☐ Sat From _____ to _____

☐ Wed From _____ to _____

☐ Varies week to week ☐ Yes ☐ No

Household Member 2 Name

Employer / School / Training Information Name

Activity Phone Number

Start Date / End Date

Address

Household Member Work / School / Training Schedule- Include travel time needed

☐ Sun From _____ to _____	☐ Thurs From _____ to _____
☐ Mon From _____ to _____	☐ Fri From _____ to _____
☐ Tues From _____ to _____	☐ Sat From _____ to _____
☐ Wed From _____ to _____	☐ Varies week to week ☐ Yes ☐ No

Household Member 3 Name

Employer / School / Training Information Name

Activity Phone Number

Start Date / End Date

Address

Household Work / School / Training Schedule- Include travel time needed

☐ Sun From _____ to _____	☐ Thurs From _____ to _____
☐ Mon From _____ to _____	☐ Fri From _____ to _____
☐ Tues From _____ to _____	☐ Sat From _____ to _____
☐ Wed From _____ to _____	☐ Varies week to week ☐ Yes ☐ No

Step 12: Tell us about the child(ren) who need(s) Early Care and Education *Child

Child 1 - Name (First, Middle, Last)

Child's Mother's Maiden Name

City of Birth

Relationship to Applicant

Child's Preferred Spoken Language

Is the child a U.S. Citizen or a Qualified Non-Citizen? **Note:** You must provide verification in order to receive ECE Assistance.

☐ Yes ☐ No - My child is **NOT** a U.S. Citizen or a Qualified Non-Citizen

Child's Needs: Does the child require Protective Child Care?

☐ Yes ☐ No - My child does **NOT** require Protective Child Care

If **YES**, is there a case plan?

☐ Yes ☐ No - My child does **NOT** have a case plan

Is the child in Head Start?

☐ Yes - What is their schedule? From _____ to _____ ☐ No - My child is **NOT** in Head Start

Is the child in kindergarten?

If **YES**, is the child AM or PM or Full-day?

Yes No ☐ AM ☐ PM ☐ Full-day

Program Name

Program Address

City

State

Zip Code

↑ office Will Complete *

Child 2

Child 2 - Name (First, Middle, Last)		Child's Mother's Maiden Name		City of Birth	
Relationship to Applicant			Child's Preferred Spoken Language		
Is the child a U.S. Citizen or a Qualified Non-Citizen? Note: You must provide verification in order to receive ECE Assistance. ☐ Yes ☐ No - My child is NOT a U.S. Citizen or a Qualified Non-Citizen					
Child's Needs: Does the child require Protective Child Care? If YES, is there a case plan? ☐ Yes ☐ No - My child does NOT have a case plan				☐ Yes ☐ No - My child does NOT require Protective Child Care	
Is the child in Head Start? ☐ Yes - What is their schedule? From _____ to _____ ☐ No - My child is NOT in Head Start					
Is the child in kindergarten?		If YES, is the child AM or PM or Full-day?			
Yes No		☐ AM ☐ PM ☐ Full-day			
Program Name		Program Address		City	State Zip Code

Child 3

Child 3 - Name (First, Middle, Last)		Child's Mother's Maiden Name		City of Birth	
Relationship to Applicant			Child's Preferred Spoken Language		
Is the child a U.S. Citizen or a Qualified Non-Citizen? Note: You must provide verification in order to receive ECE Assistance. ☐ Yes ☐ No - My child is NOT a U.S. Citizen or a Qualified Non-Citizen					
Child's Needs: Does the child require Protective Child Care? If YES, is there a case plan? ☐ Yes ☐ No - My child does NOT have a case plan				☐ Yes ☐ No - My child does NOT require Protective Child Care	
Is the child in Head Start? ☐ Yes - What is their schedule? From _____ to _____ ☐ No - My child is NOT in Head Start					
Is the child in kindergarten?		If YES, is the child AM or PM or Full-day?			
Yes No		☐ AM ☐ PM ☐ Full-day			
Program Name		Program Address		City	State Zip Code

Child 4

Child 4 - Name (First, Middle, Last)		Child's Mother's Maiden Name		City of Birth	
Relationship to Applicant			Child's Preferred Spoken Language		
Is the child a U.S. Citizen or a Qualified Non-Citizen? Note: You must provide verification in order to receive ECE Assistance. ☐ Yes ☐ No - My child is NOT a U.S. Citizen or a Qualified Non-Citizen					
Child's Needs: Does the child require Protective Child Care? ☐ Yes ☐ No - My child does NOT require Protective Child Care If YES , is there a case plan? ☐ Yes ☐ No - My child does NOT have a case plan					
Is the child in Head Start? ☐ Yes - What is their schedule? From _____ to _____ ☐ No - My child is NOT in Head Start					
Is the child in kindergarten?		If YES , is the child AM or PM or Full-day?			
Yes No		☐ AM ☐ PM ☐ Full-day			
Program Name		Program Address		City	State Zip Code
Does your child(ren) who needs care have a chronic health condition, developmental disability, or special need? ☐ No - My child does NOT have a chronic health condition, developmental disability, or special need ☐ Yes - Please fill out the chart below:					
Name (First, Middle, Last)			Describe Child's Specific Needs		

This Form Continues on the Next Page



Step 13: Tell us about the school attendance of the child(ren) who need(s) care

Note: Complete this section if any child(ren) is attending or will be attending Kindergarten or higher grade school

Child's Name (First, Middle, Last)	Current Grade Level	School Name and Address	School Hours (ex: 8am - 3pm)	Kindergarten Schedule	School Year Start End Date
				☐ AM ☐ PM ☐ Full Day	
				☐ AM ☐ PM ☐ Full Day	
				☐ AM ☐ PM ☐ Full Day	
				☐ AM ☐ PM ☐ Full Day	

Step 14: Please review the following information carefully and sign on the last page

BY SIGNING THIS APPLICATION:

► **For all programs (SNAP, Cash, ECE, and/or Medical Assistance), I acknowledge and agree:**

- To the questions on this form and certify, under penalty of perjury, that all my answers are correct and complete to the best of my knowledge, including information about the citizenship or immigration status of each household member applying for assistance.
- The county Job and Family Services (JFS) office may contact other persons or organizations to obtain the necessary proof of my eligibility and level of assistance and/or in some instances, I may be asked to give consent to the county JFS office to make those contacts.
- I may be required to cooperate with the child support enforcement agency (CSEA) in establishing paternity or establishing or enforcing a support order. If I am required to cooperate with the CSEA, a referral will be submitted to the agency on my behalf. I also understand that if I am not required to cooperate with the CSEA, I may request child support services by completing the Application for Child Support Services (JFS Form 07076).
- The county JFS office can assist me with getting required verifications as long as I cooperate.
- The law provides a penalty of fine or imprisonment, or both, for anyone convicted of fraudulently receiving assistance for which he or she is not eligible.
- My signature below gives the county JFS office permission to access available information in the Support Enforcement Tracking System (SETS) to verify my child/spousal/medical support income.
- The status of non-citizen household members may be subject to verification by the United States Citizenship and Immigration Services (USCIS) through the submission of information from the application to USCIS through the Systematic Alien Verification and Eligibility (SAVE) System. The submitted information received from USCIS may affect the household's eligibility and level of benefits.
- My signature below gives my consent and authorizes the county JFS office to access the Ohio Benefits Worker Portal for the purpose of verifying the citizenship status of the children in this case and for verification of the receipt of additional public assistance. I may revoke this authorization at any time by notifying the county JFS office in writing.
- You have the right to request a county conference and a state hearing if you disagree with the action taken on your case. To request a county conference you should contact your county JFS office or review your notices received in the mail.

Step 14: Please review the following information and sign (Continued)

► If I applied for SNAP benefits, I acknowledge and agree:

- By signing this application, that information will be requested from the Income and Eligibility Verification System (IEVS) and information may be verified through whatever contacts are necessary to determine my eligibility.
- Social Security Numbers (SSNs) will be used to check the identity of household members, prevent duplicate participation, and make changes to my case. If any household member does not provide their SSN, they will be designated as a non-applicant. This means they will NOT be considered as an applicant and will not be eligible for SNAP. Providing any requested information, including the SSN of each household member, is voluntary. However, failure to provide requested information to establish my eligibility for assistance will result in the denial or reduction of SNAP benefits to my household. Information collected on the application may be disclosed to law enforcement officials for the purpose of apprehending individuals fleeing to avoid the law.
- If a court of law finds me guilty of using or receiving benefits in a transaction involving the sale of a controlled substance, I will not be eligible for benefits for two years for the first offense, and permanently for the second offense.
- If a court of law finds me guilty of having used or received benefits in a transaction involving the sale of firearms, ammunition or explosives, I will be permanently ineligible to participate in SNAP upon the first offense of such violation.
- SNAP benefits are issued on the Ohio Direction Card and I am prohibited from using my SNAP benefits to purchase or sell firearms or controlled substances. I understand that I can use SNAP benefits to only buy eligible items. I cannot use SNAP benefits to buy non-food items such as alcoholic drinks, tobacco, etc.
- Any member of my household who intentionally breaks the rules may not get SNAP for one year for the first offense, two years for the second offense, and permanently for the third offense.
- If a court of law finds me guilty of having trafficked benefits for a total amount of \$500 or more, I will be permanently ineligible to participate in SNAP upon the first offense of such violation.
- I am prohibited from selling, trading or purchasing SNAP benefits and cannot use someone else's SNAP benefits for my household. I can be disqualified from the SNAP program for any of these violations.
- I cannot use benefits to buy food for someone who is not a member of my household.
- If I am found to have made a fraudulent statement or representation with respect to the identity or place of residence in order to receive multiple SNAP benefits simultaneously, I will be ineligible to participate in the SNAP for a period of 10 years.
- The information provided with my application for SNAP benefits will be subject to verification by Federal, State and local officials to determine if the information is factual and if any information is incorrect, my SNAP benefits may be denied. I may be subject to criminal prosecution for knowingly providing incorrect information.
- If I receive SNAP benefits that I should not have gotten:
 - I may be ordered to repay the benefits.
 - I may be charged with fraud.
 - I may be fined (up to \$250,000) or sent to prison (up to 20 years) or both.
 - I may be prohibited from receiving benefits in the future.
- I will be held liable for any SNAP benefits that I receive that I should not have gotten if my authorized representative gives incorrect information.
- If I do not agree with an action taken on my case, I can file for a county conference or a state hearing. I can ask for a county conference or state hearing online, by email or mail, or by contacting my county JFS office. I can ask someone to attend the hearing in my place with my signed authorization.
- If my case is chosen at random to make sure that I am eligible for the assistance I receive and that I am receiving the correct amount, I must cooperate if my case is reviewed. If I refuse to cooperate with a review, my benefits may be terminated.
- Within 60 days of applying and at any time while receiving benefits, an employed or self-employed person is not to voluntarily and without good cause, quit the job or reduce work hours to less than 30 hours per week or to earning less than the federal minimum wage x 30 hours to remain eligible to participate in SNAP.

► If I applied for Cash Assistance benefits, I acknowledge and agree:

- By signing this application and receiving OWF Cash Assistance, I may be required to cooperate with the local Child Support Enforcement Agency (CSEA) in establishing paternity or establishing or enforcing a support order. If I am required to cooperate with the local Child Support Enforcement Agency (CSEA), a referral will be submitted to the agency on my behalf and any rights to all support owed to me and the minor children in the assistance group will be assigned to the State of Ohio.

Step 14: Please review the following information and sign (Continued)

- By signing this application and receiving OWF Cash Assistance, I am assigning to the State of Ohio any rights to child or spousal support that is owed to me and/or the minor children in the assistance group during the Ohio Works First eligibility period.
- Cash benefits are issued on the EPPICard™. The EPPICard™ can be used at MasterCard member banks, ATMs and most retailers that accept MasterCard. I cannot use my EPPICard at liquor stores, casinos, gaming establishments, or any retail establishments that provide adult entertainment in which performers disrobe or perform in an unclothed state for entertainment purposes.
- I must activate my EPPICard™ within 90 days from when benefits and my first card is issued and that if my EPPICard™ is not activated within 90 days, my benefits will be removed from my account.
- ▶ **If I applied for Early Care and Education (ECE), I acknowledge and agree:**
 - My county JFS office or DCY may share approval, denial, and submission status of my application to the program(s) listed on this application or to any program named as a result of a change to my application.
 - I understand that the sharing of this information to any program not listed on this application shall require the signing of a separate release per Ohio Revised Code.
 - I will be able to use ECE only for children who are eligible and only up to the maximum hours authorized by the county JFS office. To remain eligible for PFCC benefits, the required copayment (if applicable) must be paid by me to the program. Failure to pay the required copayment may result in termination of PFCC benefits.
 - If I am approved for services, I will be responsible for accurately recording my child's attendance at the program by utilizing an automated attendance tracking system. This includes registering in the system and creating personal identification information that I will use to access the system and to serve as my electronic signature. I understand that my program is not permitted to record my child's attendance on my behalf and may not have access to my personal identification information. I understand that the attendance tracking system may take my photo or a photo of my designee/sponsor as part of the login and logout process. I understand that I am responsible for approving any changes that my program makes in the attendance tracking system regarding my child's attendance at the program.
 - If my child attends a Step Up To Quality rated program, and if an assessment is completed on my child, the data will be collected and reported to DCY.
 - I have received an explanation regarding the requirements for determining eligibility, the reasons why I may not be eligible, my right to a state hearing, and my responsibility for reporting changes to the county JFS office and the penalty, including possible civil action or criminal prosecution, for the intentional withholding or falsification of information or misuse of benefits, including misuse of the automated child care attendance tracking system.
 - I must report any changes which affect my PFCC eligibility to the county JFS office, including changes in my income goes above 300% of the federal poverty level, long-term changes in participation in my qualifying activity and address changes. I understand that I must report changes within 10 days of the date they occur.
 - My signature also gives consent to issue a system generated statewide student identifier (SSID) for each child listed on this application.
 - Information About ECE Programs:
 - Parents may select any program approved to offer ECE. These programs include centers, family child care homes, preschools, school-age care, in-home aides and child day camps located throughout the state of Ohio.
 - If you would like assistance with selecting a program, you may contact your local Child Care Resource and Referral Agency.
 - You may use our Child Care Directory to look for programs that fit your child care needs at <https://childcaresearch.ohio.gov>. The directory allows you to search by location, type of program, services offered and days and hours of operation. Information is provided about each program including Step Up To Quality rating, any additional accreditation or affiliation, licensing inspections and substantiated complaints.
 - Step Up To Quality helps families choose programs that go beyond the minimum standards of licensing. Rated programs demonstrate higher levels of quality in a variety of ways. If you would like more information about the Step Up To Quality program, visit the DCY website at <https://childrenandyouth.ohio.gov/for-providers/step-up-to-quality>.
 - You may also visit our website to learn more about Medicaid health screenings and early intervention services for your child. For this information, go to Healthchek | Medicaid and <https://medicaid.ohio.gov/families-and-individuals/citizen-programs-and-initiatives/healthchek> and for Early Intervention services go to <https://ohioearlyintervention.org/>.
 - If you would like to make a complaint about a suspected violation of licensing rules, misuse, or fraud you may contact the Family and Customer Support Center at 1-844-234-5437.

► **If I applied for Medical Assistance benefits, I acknowledge and agree:**

- Under penalty of perjury, I have disclosed all annuities and other similar financial devices in which I and/or my spouse have any interest.
- By signing this application and receiving Medicaid, I am assigning to the State of Ohio any rights to medical support and any rights to payments by a liable third party for medical assistance owed to me and/or to the minor child(ren) in my assistance group. I understand that I must tell the Ohio Department of Medicaid about any health insurance I have or about any third party responsible for my medical expenses. I give the Ohio Department of Medicaid the right to pursue medical support from an ex-spouse or parent. If I think that cooperating to collect medical support will harm my child(ren) or myself, I understand that I can tell the Ohio Department of Medicaid and I may not have to cooperate.
- That the Ohio Department of Medicaid will check my answers using Social Security numbers and information from computer data sources, including the Internal Revenue Service (IRS), the Social Security Administration (SSA), the Department of Homeland Security (DHS), and others. If the information does not match, the Ohio Department of Medicaid may ask me to send more information.
- The Ohio Department of Medicaid will get information about my financial resources from banks, credit unions, or other financial institutions to determine my eligibility for medical assistance. Authorization to get this information remains in effect until:
 - My application for medical assistance is denied; or
 - My eligibility for medical assistance ends; or
 - I inform the Ohio Department of Medicaid in writing that I wish to end my authorization.
- If I refuse to authorize the Ohio Department of Medicaid to get information about me from financial institutions, or I decide to end my authorization for the Ohio Department of Medicaid to get information about me from financial institutions, I understand that my medical assistance may be denied or discontinued.
- If I am permanently institutionalized or age 55 or older when I receive Medicaid benefits, after my death the Estate Recovery Program may recover payments for the cost of my care paid by Medicaid from my estate. The cost of my care may include the capitation payment that Medicaid pays to my managed care plan, even if the capitation payment is greater than the cost of the services I actually received.
- I authorize any person who furnishes health care, medical supplies, or services to give the Ohio Department of Medicaid, the Ohio Department of Job and Family Services, or the Ohio Department of Health any information related to the extent, duration, and scope of services provided under the Medicaid program, WIC, and other medical assistance programs. I understand that I authorize the previously mentioned departments to exchange any information I have provided to enable the departments to determine my eligibility for medical assistance benefits.
- The Medicaid Program requires enrollment for most recipients into a Managed Care Plan. You will receive information in the mail about this if you are determined eligible for Medicaid.
- The Healthcheck program offers preventative healthcare services to all Medicaid eligible children under the age 21 and pregnant woman. A Medicaid eligible child may receive free Healthcheck screenings for vision and hearing.

I authorize _____ to be my representative for _____ program.

(Name of Auth Rep)

(Ex. SNAP, OWF)

For Medicaid: You may be asked to provide further documentation of the authorization in order to comply with OAC 5160-1-33.

- If you need more than one authorized representative, please contact your county JFS office.

 Signature of Applicant OR Authorized Representative

Print Name of Applicant OR Authorized Representative

- END OF APPLICATION -

IS YOUR APPLICATION COMPLETE?

Is anything missing:

- ☐ Birth Certificate
- ☐ Proof of Residency (utility bill)
- ☐ All written parts of the application are filled in and signed
- ☐ Child Care assistance information filled in and signed
- ☐ Immunizations
- ☐ Custodial paperwork (if applicable)
- ☐ Appropriate proof of income provided
- ☐ I have initialed the bottom of each page

Please submit all preschool application documents to

Stephanie Middleton

stephanie.middleton@ovesc.org

PLEASE KEEP THESE FORMS TO COMPLETE:

The medical and dental forms that need completed by your CHILD'S PHYSICIAN are attached.

These forms need to be completed and returned within 30 days of your child beginning preschool.

Please detach these two forms and return to the address below WHEN COMPLETE:

Ohio Valley Educational Service Center

OVESC BRIGHT BEGINNINGS PRESCHOOL

Broughtons Complex 3 - Building 16B

2333-B St. Rt. 821

Marietta, Ohio 45750

Fax: 1-740-439-0012

Thank you!



Child Medical Statement

Required for ALL children enrolled in Preschool, Special Education, and Early Childhood Education Grant Programs

Child's Full Name: _____ Date of Birth: ____/____/____

School: _____ Age: ____ Height: ____ Weight: ____

Physician's Name: _____

I authorize my physician to release the completed medical statement to Bright Beginnings Preschool. (Fax: 740-376-5809)

Parent/Guardian Signature: _____ Date: _____

To be completed by Child's Physician

Allergies: _____			History: _____		
☐ Normal	☐ Abnormal	General Appearance	☐ Normal	☐ Abnormal	Speech
☐ Normal	☐ Abnormal	Posture, Gait	☐ Normal	☐ Abnormal	Teeth, Gums
☐ Normal	☐ Abnormal	Nose, Mouth, Pharynx	☐ Normal	☐ Abnormal	Head
☐ Normal	☐ Abnormal	Bones, Joints, Muscles	☐ Normal	☐ Abnormal	Heart
☐ Normal	☐ Abnormal	Skin	☐ Normal	☐ Abnormal	Lungs
☐ Normal	☐ Abnormal	Muscular Coordination	☐ Normal	☐ Abnormal	Extremities
☐ Normal	☐ Abnormal	Eyes	☐ Normal	☐ Abnormal	Abdomen
☐ Normal	☐ Abnormal	Symmetrical Light Reflex	☐ Normal	☐ Abnormal	Genitalia
☐ Normal	☐ Abnormal	External Aspects	☐ Normal	☐ Abnormal	Development
☐ Normal	☐ Abnormal	Ears	☐ Normal	☐ Abnormal	Social/Emotional
☐ Abnormal	☐ Normal	Glands (Lymphatic/Thyroid)	☐ Abnormal	☐ Normal	Neurological

Assessments/Screenings:

Lead	☐ No	☐ Yes: Date- _____	Vision Screen	☐ No	☐ Yes: Date- _____
Hemoglobin	☐ No	☐ Yes: Date- _____	Hearing Screen	☐ No	☐ Yes: Date- _____

Medications: _____

Limitations for school or health conditions (including food supplements, modified diets, activity restrictions, and health services): _____

Please attach a copy of the most recent Immunization record
(required by Section 3313.671 of Ohio Revised Code and for attendance in preschool)

Exempt from immunizations: ☐ Religious Convictions ☐ Health Concern ☐ Other

I have examined this child and found he/she is in suitable condition for participation in group care.

Signature of Physician/Physician's Assistant/Clinical Nurse Specialist/Certified Nurse

Date of Exam

Printed Name: _____

Address: _____

Phone: (____) _____ - _____ FAX: (____) _____ - _____



Child Dental Exam

Parent/Guardian: To ensure good dental health, every child needs to have a dental exam. This checkup may be done by your own dentist. If you/your child does not have a primary dentist, please call 740-373-6669 for the names/phone numbers of local dentists taking new patients.

Child's Full Name: _____ Date of Birth: ____/____/____

School: _____ Age: _____

Dental Clinic/Dentist's Name: _____

*I authorize my dental clinic/dentist to release this document to Bright Beginnings Preschool.
(Fax: 740-376-5809)*

Parent/Guardian Signature: _____ Date: _____

To be completed by Child's Dentist

This child received the following treatment in my office:

- | | |
|---|---|
| ☐ Dental Exam | ☐ Emergency Treatment: _____ |
| ☐ X-Rays Taken | ☐ Fillings |
| ☐ X-Rays Read | ☐ Extractions |
| ☐ Cleaning | ☐ Steel Crowns |
| ☐ Topical Fluoride Application | ☐ Space Maintainers |
| ☐ Sealants | ☐ Other: _____ |

☐ **ALL TREATMENTS ARE COMPLETE.**

☐ **TREATMENTS ARE NOT COMPLETE. THE FOLLOWING IS STILL NEEDED:**

- | | |
|---|--|
| ☐ Take X-Rays | ☐ Fillings |
| ☐ Read X-Rays | ☐ Extractions |
| ☐ Sealants | ☐ Steel Crowns |
| ☐ Topical Fluoride Application | ☐ Space Maintainers |
| ☐ Other: _____ | |

I have examined this child and found he/she is in suitable condition for participation in preschool.

Signature of Dentist _____

Date of exam _____

Printed Name: _____

Address: _____

Phone: (____) _____ - _____ FAX: (____) _____ - _____