Child Profile

Child's Name _____
First Middle Last

Date of Birth _____ Gender (Male/Female) _____

Race/Ethnicity (check all that apply): ____ White ____ Black/African American
____ Asian ____ American Indian/Alaska Native

Is the child Hispanic/Latino? ____ Yes ____ No

Primary language spoken at home _____

Child lives with/residential parent is (check all that apply): ____ Father ____ Mother

Father's Name _____ Phone # _____
First Middle Last

Father's address _____
Street Address City State Zip Code

Mother's Name _____ Phone # _____
First Middle Last

Mother's Maiden Name _____ Place of Child's Birth _____
City/State

Child's Address _____
Street Address City State Zip Code

Child's School District of Residence _____

Preschool Tuition

Tuition Assistance is available with proof of income.

Income $_____/Month $_____/Year

(Income Information used to determine eligibility for Early Childhood Education Program (ECE) and state reporting only)

Number of People in Household _____

____ **I prefer not to provide income information. By initialing, I understand I will be responsible for paying full preschool tuition due at the beginning of each month.**

Family Profile

Are the parents: ____ Married ____ Separated ____ Divorced ____ Live Together

With whom does the child reside most of the time? (check all that apply)
____ Mother ____ Father ____ Other, please identify name/relationship _____

How many other children live in the home?(Name/Ages)

_____

Are there other adults that live in the home?____ If yes, who? _____

About My Child

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's other favorites are: _____

Play and Social Experiences

Has your child attended a preschool setting previously? _____ For how long? _____

How did your child do there? _____

How does your child get along with other children? _____

How does your child prefer to play: ____ alone ____ with others

My child frequently exhibits the following behaviors:

___ Hitting	___ Kicking	___ Biting
___ Scratching	___ Fighting	___ Name Calling
___ Shy	___ Withdrawn	___ Friendly
___ Outgoing	___ Tattling	___ Tantrums

My child likes to:

___ Listen to stories	___ Draw and Color	___ Play with other children
___ Play outside	___ Play alone	___ Play inside
___ Play quiet games	___ Play pretend/make-believe	
___ Other _____		

My child doesn't like to: _____

I would like you to be aware of the following about my child's health, development, behavior, family or home life: _____

What concerns do you currently have regarding your child?

_____

What goals do you have for your child?

_____

ENROLLMENT FORM

Child's Name: First Middle Last	Child's Date of Birth:

Did mother have any unusual physical/emotional illness during pregnancy? Yes No
If yes, please explain:

Age of mother when child was born:	Birth weight of child:

The child was: (Please circle) 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 Circle) 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:

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 taken?
1.		
2.		
3.		

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

Emergency Care Card

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

Child's Name _____ DOB _____

_____

Street Address City State Zip Code

Mother's Name _____ Daytime Phone # _____
Place of Employment _____ Secondary Phone # _____
Father's Name _____ Daytime Phone # _____
Place of Employment _____ Secondary Phone # _____

Emergency Contact _____ Relationship _____
Daytime Phone # _____ Secondary Phone # _____

Emergency Contact _____ Relationship _____
Daytime Phone # _____ Secondary Phone # _____

Emergency Dismissal Information

In the event of an emergency dismissal, I request that my child, _____, be sent to the home of:
Name _____ Relationship _____
Address_____ Phone # _____

Part 1 or 2 must be completed.

Part 1 - To Grant Consent for Treatment.

Doctor _____ Phone # _____
Dentist _____ Phone # _____
Medical Specialist _____ Phone # _____
Preferred Local Hospital _____ Phone # _____
Preferred Emergency Room _____ Phone # _____

Part 1, Continued

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the (1) administration of any treatment deemed necessary by the above named physician, or in the event the designated physician is not available, by another licensed physician; and (2) the transfer for the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians, concurring in the necessity for such surgery, are obtained prior to the performance of the surgery.

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

_____

_____

_____

_____ _____

Date Signature of Parent or Guardian

Permission for Emergency Transport of Child

I give East Guernsey Local School District Preschool permission to transport my child _____, or to arrange emergency transportation, to the appropriate medical facility for emergency medical/dental care or to the nearest accessible hospital or clinic.

_____ _____

Date Signature of Parent or Guardian

Part 2 - Refusal to Grant Consent for Treatment

I do NOT give my consent for emergency medical treatment of my child, _____, in the event of illness or injury requiring emergency treatment. I request that the school authorities take the following actions:

_____

_____

_____ _____

Date Signature of Parent or Guardian

Program Authorization Form

Child's Name: _____ **Date of Birth:**_____

My child attends the following preschool/day care center: _____

My child's teacher(s) name is/are: _____

Authorization for Participation and Release of Information

1. 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 East Guernsey Local School District Preschool as well as various other community agencies.
2. East Guernsey Local School District Preschool has my permission to conduct the following developmental assessments (which may include but are not limited to, Battelle Developmental, Early Childhood Outcomes Summary, etc.) I understand that my child's teacher/specialist will provide feedback regarding the assessment to myself and other members working 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.
3. I understand that there may be some screenings/assessments that are not to be conducted at my child's preschool setting and that I may need to obtain these screening/assessments through my child's doctor, dentist, local health department or other community agency. 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.

I, _____**, parent/guardian of** _____**,**
Parent/Guardian Name **Child's Name**

Authorize the East Guernsey Local School District Preschool to release all medical, developmental, educational and psychological information concerning my child to the appropriate agencies, as noted above. By signing, I am verifying that I have read the information above and I agree to comply with the above regulations to the best of my ability.

_____ _____
Signature of Parent/Guardian **Date**

Program Authorization Form

Authorization to Release Child

My child **may be released,** to his/her parent/guardian and the following people only:

Name:	Name:	Name:	Name:
Address:	Address:	Address:	Address:
Phone:	Phone:	Phone:	Phone:
Relationship to Child:	Relationship to Child:	Relationship to Child:	Relationship to Child:

If your child **may NOT be released** to any individual(s): Please attach a copy of restraint order papers and/or Divorce decree, if appropriate. Please make sure to consult with your child's teacher about who they may not be released to.

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. Furthermore, 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. Furthermore, I do not grant permission for my child to participate in walking field trips that are close to my child's school.

Program Authorization Form

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, 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.

Authorization for Release of Roster Information: Please initial on the appropriate line below:

_____ Yes, I grant permission to release the following information (child's name, telephone number and/or parent/guardian names) to other parents in the preschool class.

_____ No, I do not grant permission to release the following information (child's name, telephone number and/or parent/guardian names) to other parents in the preschool class.

Ohio Department of Job and Family Services
Ohio Department of Education

EARLY CHILDHOOD EDUCATION ELIGIBILITY SCREENING TOOL

Tell us about you (the applicant)

First Name	MI	Last Name	
Address			Today's Date
City	State	County	Zip Code
Phone Number ( )	Additional Phone Number ( )	E-mail Address	

Tell us about the people in your home

Name *(First, Middle, Last)*	Relationship to You *(spouse, son, friend, etc.)*	Race	Hispanic or Latino *Y or N*	Spoken Language	Date of Birth	Gender *M or F*	U.S. Citizen *Y or N*
	Self	☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					

Tell us about your needs for your child(ren)

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

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

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

Tell us about your finances

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

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

If yes, please complete the table below.

Name	Type of Income	Amount of Income *(before taxes)*	How Often Received *(weekly, bi-weekly, etc)*	Date Last Received	Work or School Schedule *(please list times)*
					☐ Sun ____ ☐ Thurs ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____
					☐ Sun ____ ☐ Thurs ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____
					☐ Sun ____ ☐ Thurs ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____
					☐ Sun ____ ☐ Thurs ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____
					☐ Sun ____ ☐ Thurs ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____

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

How Much?

Signature of Applicant	**Date**

East Guernsey Local Preschool
PO Box 128, Old Washington OH 43768
Phone: 740-489-5190

Child Medical Statement

Child's Name: _____ DOB: _____ Date of Exam: _____

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

Height: _____ Weight: _____ Allergies: _____ History: _____

	Normal	Abnormal		Normal	Abnormal
General Appearance			Glands (Lymphatic/Thyroid)		
Posture, Gait			Nose, Mouth Pharynx		
Speech			Teeth, Gums		
Head			Heart		
Skin			Lungs		
Eyes			Abdomen		
*symmetrical light reflex			Genitalia		
*external aspects			Bones, Joints, Muscles		
Development			Extremities		
Ears			Muscular Coordination		
Social/Emotional			Neurological (gross, fine, sensory motor)		

Assessments/Screening	**Completed (please circle one)**	**Date**	**Assessments/Screening**	**Completed (please circle one)**	**Date**
Lead	Yes No		Vision screen	Yes No	
Hemoglobin	Yes No		Hearing screen	Yes No	

Medications: _____

Limitations or health conditions(including food supplements/modified diets, activity restrictions, health services needed at school): _____

_____

Immunization Record (Required by Section 3313.671 of Revised Code and for attendance in preschool program)
Please attach a copy
*Exempt from immunizations: _____ Religious conviction _____ Health concern _____ Other

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

_____

Physician/Physician's Assistant/Advanced Practice Nurse Printed Name Date of exam

_____

Address Telephone Fax

Dental Form

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

Child's Name _____ Date of Birth _____

Parent/Guardian Name _____ Phone # _____

Address: _____
Street Address City State Zip Code

I authorize my dental clinic to release this completed form to East Guernsey Local School District Preschool.

_____ _____
Parent/Guardian Signature Date

To be completed by the dentist:

This child received the following treatment in my office:

- ____ **Dental Exam**
- ____ **X-Rays taken**
- ____ **X-Rays read**
- ____ **Cleaning**
- ____ **Topical Fluoride Application**
- ____ **Sealants**
- ____ **Fillings**
- ____ **Emergency Treatment**
- ____ **Extractions**
- ____ **Steel Crowns**
- ____ **Space Maintainers**
- ____ **Other--Please explain:** _____

_____

_____

____ **ALL TREATMENTS ARE COMPLETE.**

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

- ____ **Take X-rays**
- ____ **Read X-rays**
- ____ **Topical Fluoride Application**
- ____ **Sealants**
- ____ **Fillings**
- ____ **Extractions**
- ____ **Steel Crowns**
- ____ **Space Maintainers**
- ____ **Other--Please explain:** _____

_____

_____

_____ _____ _____ _____
Dentist Printed Name **Dentist Signature** **Telephone #** **Date of Exam**