

# LAKE COUNTY ESC PRESCHOOL PROGRAM

Please select preschool:  Perry  Fairport

**PERRY AND FAIRPORT REGISTRATIONS :**

PLEASE MARK YOUR PREFERENCE IN NUMBER ORDER.

PREFERENCE WILL BE CONSIDERED IF POSSIBLE BASED ON AVAILABILITY

\_\_\_\_\_ FULL DAY PRESCHOOL \_\_\_\_\_ HALF DAY PRESCHOOL



**PRESCHOOL REGISTRATION FOR \_\_\_\_\_**

SCHOOL YEAR



| <b>Documentation Required to Enroll Children in Preschool</b> |  |
|---|--|
|   | All registration forms must be fully completed for each child                      |
|   | Proof of Residency must be provided– see below-(copy)<br>2 forms required by Perry |
|   | Birth Certificate for each child-(copy)  |
|   | Parent/Guardian ID-(copy)  |
|   | Custody Papers for each child (if applicable)-(copy)                               |
|   | Copy of IEP (if child has special needs)-(copy)                                    |
|   | Medical Statement/Physician signature-included in packet                           |
|   | Current Immunization Records for each child  |

**ACCEPTABLE FORMS OF PROOF OF RESIDENCY**

- Utility Bill (Telephone bill, cable bill and mortgage statement not accepted as proof of residency)
  - Gas  Electric  Water
- Rental Agreement / Purchase Agreement / Construction Agreement
- Notarized Letter from Homeowner



(REGISTRATION MAILING ADDRESS)

**LAKE COUNTY ESC PRESCHOOLS**

**ATT: AMY**

**8221 AUBURN RD**

**CONCORD, OHIO 44077**

**440-354-7090**

[www.esc-lc.org](http://www.esc-lc.org)

[apalker@lakeesc.org](mailto:apalker@lakeesc.org)

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## ENROLLMENT FORM

**Important! Read before completing this form.**

The laws of the State of Ohio (Ohio Revised Code Section 3313.64, 3313.08, 3319.04, 3327.06) provide that a school age child under the age of 18 years can attend school only in the district in which his/her parent(s) or other court appointed guardian have established legal residence.

Children found to be attending school in defiance of the residency conditions set forth above are to be removed from the school district rolls and not to be permitted to continue to attend in that district. The District reserves the right to charge tuition for student attendance in violation of the residency requirement.

Date: \_\_\_\_\_ School Year: \_\_\_\_\_ Is this a temporary address? \_\_\_\_\_

### Student Information

| Last Name | First Name | Middle Name | Date of Birth | Gender | Birth City |
|-----------|------------|-------------|---------------|--------|------------|
|           |            |             |               |        |            |

**Student lives with:**       Both parents (same residence)       Both parents (shared custody)  
 Biological Mother     Biological Father     Relative/Guardian     Court Placement     Other \_\_\_\_\_

### Residential Parent / Guardian Information

|  |  |  |            |
|--|--|--|------------|
| <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Other |  | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Other |            |
| Name: _____  |  | Name: _____  |            |
| Address: _____   |  |  |            |
| City: _____  |  | State: _____   | Zip: _____ |
| Home Phone: _____  |  |  |            |
| Work Phone: _____  |  | Work Phone: _____  |            |
| Cell Phone: _____  |  | Cell Phone: _____  |            |
| Email: _____   |  | Email: _____   |            |

### Non-Residential Parent Information – if Applicable

|  |                   |
|--|-------------------|
| Select Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father |                   |
| Name: _____  | Home Phone: _____ |
| Address: _____   | Work Phone: _____ |
| Email: _____   | Cell Phone: _____ |

### Student ethnic background (If a selection is not made, the child will be classified as Multi-Racial)

Is student Hispanic/Latino? Yes  No       Please further indicate student's ethnicity by selecting **ALL** that apply:

- American Indian-Alaskan Native     Asian     Black/African American  
 White     Native Hawaiian/Pacific Islander    (Multiracial- choose all that apply)

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## HEALTH RECORD

Rule 3301-37-05 of the Administrative Code requires preschool programs to secure health information from a child's parent no later than the first day of attendance unless otherwise indicated.

| Name of Child (print or type) | Date of Birth | Name of Parent or Guardian |
|-------------------------------|---------------|----------------------------|
|                               |               |                            |

1. Allergies (List all allergies affecting the child and any special precautions or treatments indicated for these allergies).
  
  
  
  
  
  
  
  
  
  
2. Medications (List all medications currently being administered to the child).
  
  
  
  
  
  
  
  
  
  
3. Chronic Physical Problems (List all chronic physical problems affecting the child).
  
  
  
  
  
  
  
  
  
  
4. History of Hospitalizations (List dates of all hospitalizations of the child).
  
  
  
  
  
  
  
  
  
  
5. Diseases (List all diseases the child has had).
  
  
  
  
  
  
  
  
  
  
6. Please list any dietary supplements and/or fluoride supplements.

Name of Person Completing this Form \_\_\_\_\_ Date \_\_\_\_\_

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## Statement of Understanding

I, \_\_\_\_\_, state the following to be true:

1. I am the parent/guardian and legal custodian of the minor child(ren) listed:

Name

Birth date

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

2. My residence is \_\_\_\_\_ and I intend to reside there on a permanent basis with the above-referenced child(ren). I began residence at this location on \_\_\_\_\_, \_\_\_\_\_; and intend on continuing to reside at this location.

3. I rent/own/other (circle one) the real property where I reside;  
Should another situation exist, please explain:

\_\_\_\_\_  
\_\_\_\_\_

4. I do not maintain a primary residence outside of the \_\_\_\_\_ Local School District boundaries;

5. I have provided the \_\_\_\_\_ Local School District registration personnel an official copy of any and all current court orders from the Domestic Relations, Juvenile, Probate or any other Court which has exercised jurisdiction over the custody or residency of the child(ren) which are being registered with the Local Schools;

6. The child(ren) which are being registered are not currently expelled or excluded from any other school;

7. I agree to immediately inform the Local School District, Office of the Supervisor of Student Services, of any change in my residence and/or standing as legal custodian and/or legal guardian of the child(ren) which are being registered, and to provide a certified copy of any court order which affects the custody or residency of said child(ren), which may be issued in the future.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

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## EMERGENCY MEDICAL CONTACTS AND TRANSPORTATION AUTHORIZATION

### *TO BE COMPLETED BY ADULT HAVING LEGAL AUTHORITY OVER THE STUDENT*

The purpose of this form is to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority when parents or guardians cannot be reached.

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_  
(Last) (First) (Area Code)  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

In situations where the parent cannot be reached the student may be released to the following:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

### **PART I - To GRANT CONSENT**

I hereby give my consent for the following medical care providers and local hospital/emergency room to be called:

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_ Local Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by the above named doctor or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

**Signature of custodial/residential parent:** \_\_\_\_\_ **Date**

### **PART II - DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART I**

#### **PART II – REFUSAL TO CONSENT**

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

**Signature of custodial/residential parent:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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## PARENT ROSTER INFORMATION

In accordance with Rules 5101:2-12-54 of the Ohio Administrative Code, a roster for each group of children, which includes names and telephone numbers of parents, custodians, or guardians of children attending the center must be prepared annually and given to parents, custodians, or guardians upon request.

I \_\_\_\_\_ would like my name and telephone number to be included on this roster.

I \_\_\_\_\_ would **not** like my name and telephone number to be included on this roster.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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## PHOTOGRAPH, VIDEO, AND INTERVIEW RELEASE

### Child's Name:

I hereby give permission to use photographs/videos of me and/or my family and information obtained through personal interviews in any of their publications, press releases, marketing, fundraising or community relations activities.

**Signature:** \_\_\_\_\_

**Relationship to Subject:** \_\_\_\_\_

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## AUTHORIZATION TO RELEASE FORM

If I am unavailable, the following people have permission to pick up my child,

|             |        |             |       |
|-------------|--------|-------------|-------|
| Name:       |        | Name:       |       |
| Address:    | City:  | Address:    |       |
| Home Phone: | Cell : | Home Phone: | Cell: |

I understand that they will be asked for a photo ID and I am to call ahead if I am unable to pick up my child.

**Parent Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

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## DEVELOPMENTAL AND HEALTH SCREENING PARENTAL CONSENT

The Ohio Department of Education's Office of Early Childhood & School Readiness requires that each child obtain a health screening and developmental screening. Therefore, I understand that in order for my child to participate in the preschool program he or she will be screened at school within the first 60 days.

**Parent Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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## PARENT INTERVIEW

Name of Child: \_\_\_\_\_ Date: \_\_\_\_\_

### FAMILY STATUS

Is this child your  Natural  Adopted  Foster child?  
Is there any divorce?  Yes  No  
Have there been any deaths in immediate family?  Yes  No

Are you working with any other community service that you would like us to know about? List agencies. \_\_\_\_\_

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### ACTIVITIES

What does your child like to play with at home?  
\_\_\_\_\_  
\_\_\_\_\_

Does your child play with friends outside the home other than school?  
\_\_\_\_\_

Does your child participate in outings such as shopping, visiting relatives, etc.?  
\_\_\_\_\_

Describe the way in which you handle behavior problems?  
\_\_\_\_\_  
\_\_\_\_\_

Is there anything else that you would like us to know about your child?  
\_\_\_\_\_  
\_\_\_\_\_

List all school aged siblings/step-siblings who live at home with the child for whom this form is being completed

| First Name | Last Name | M.I. | Gender | Age | Birth Date | Legal Guardian |
|------------|-----------|------|--------|-----|------------|----------------|
|            |           |      |        |     |            |                |
|            |           |      |        |     |            |                |
|            |           |      |        |     |            |                |

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**We are required by the Ohio Department of Education to report income levels for families of ALL students enrolled in ODE licensed preschool programs. Following are the Poverty Guidelines published by the US Dept of Health and Human Services. Please circle the appropriate family size unit and income level for your household. Please note these are annual amounts. If your household brings in more than the amount in the 200% column, just write the word "more" in the outside margin and circle it. We do not need to know the amount. YOU MAY CHOOSE TO DO AS INSTRUCTED ABOVE OR CHECK THE REFUSE TO ANSWER BELOW. EITHER WAY WE MUST RECEIVE THIS FORM BACK FROM YOU.**

**Please return this form with other registration materials.**

**Student Name** \_\_\_\_\_

United States Department of Health and Human Services

### FEDERAL POVERTY GUIDELINES\*

| Size of Family Unit | 100% Poverty Level | 101% - 125% Poverty Level | 126% - 150% Poverty Level | 151% - 175% Poverty Level | 176% - 200% Poverty Level |
|---------------------|--------------------|---------------------------|---------------------------|---------------------------|---------------------------|
| 1                   | 0-\$12,490         | \$12,491-\$15,613         | \$15,614-\$18,735         | \$18,736-\$21,858         | \$21,859-\$24,980         |
| 2                   | 0-\$16,910         | \$16,911-\$21,138         | \$21,139-\$25,365         | \$25,366-\$29,593         | \$29,594-\$33,820         |
| 3                   | 0-\$21,330         | \$21,331-\$26,663         | \$26,664-\$31,995         | \$31,996-\$37,328         | \$37,329-\$42,660         |
| 4                   | 0-\$25,750         | \$25,751-\$32,188         | \$32,189-\$38,625         | \$38,626-\$45,063         | \$45,064-\$51,500         |
| 5                   | 0-\$30,170         | \$30,171-\$37,713         | \$37,714-\$45,255         | \$45,256-\$52,798         | \$52,799-\$60,340         |
| 6                   | 0-\$34,590         | \$34,591-\$43,238         | \$43,239-\$51,885         | \$51,886-\$60,533         | \$60,534-\$69,180         |
| 7                   | 0-\$39,010         | \$39,011-\$48,763         | \$48,764-\$58,515         | \$58,516-\$68,268         | \$68,269-\$78,020         |
| 8                   | 0-\$43,430         | \$43,431-\$54,288         | \$54,289-\$65,145         | \$65,146-\$76,003         | \$76,004-\$86,860         |

\* Annual Family Income

\_\_\_\_\_ **Refuse to Answer**

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

2/2019 update

## Education Rights of Homeless Students - McKinney-Vento Act

### What is McKinney-Vento?

The McKinney-Vento Homeless Assistance Act is the primary federal (U.S) law dealing with the education of children and youth in homeless situations. The McKinney-Vento Act protects the right of homeless children and youth to get to, stay in, and be successful in school while they or their families are homeless. The law focuses on maintaining school stability and school access and providing support for academic success for homeless kids. The law also requires schools and states to use child-centered, best-interest decision making



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when working with homeless children and their families to choose a homeless child's school, services, and other needed resources.

## HOME LANGUAGE SURVEY/ ENCUESTA SOBRE IDOMA EN CASA

**Federal guidelines require that this form be completed by all students at the time of enrollment.  
Las estatutos federales requieren que este formulario sea llenado por todos los estudiantes al inscribirse.**

Instructional programs for non-English or limited-English proficient students are available within the Perry Local Schools. Information about the language background of each student is necessary to determine the possible need for language development assistance. If a foreign language is listed, we will test the student's need for English as a Second Language services.

*Perry Local School ofrece programas educacionales para los estudiantes que no hablan Inles o tienen conocimiento limitado del Ingles. Es necesario obtener informacion acerca del idioma(s) que el estudiante hable para determinar la necesidad de ayuda para el desarrollo del idioma. Si Ud. pusiera otro idioma se efectuaran pruebas para determinar la necesidad de los servicios del programa del Ingles como Segundo Idioma.*

PLEASE PRINT - POR FAVOR ESCRIBA

Student Name \_\_\_\_\_  
Family Name/Apellido First Name/Primer Nombre Middle Initial/Inicial del Segundo nombre

Grade \_\_\_\_\_ Birthdate \_\_\_\_\_ Student's Country of Birth \_\_\_\_\_  
Grado Fecha de Nacimiento País de nacimiento del Estudiante

Parent/Guardian Name \_\_\_\_\_  
Nombre del Padre o tutor Family Name/Apellido First Name/ Primer Nombre

Address \_\_\_\_\_  
Dirección

City \_\_\_\_\_ State Ohio Zip Code \_\_\_\_\_  
Ciudad Código Postal

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Número de Teléfono Número de Teléfono

1. What language did your son/daughter speak when he/she first learned to talk? \_\_\_\_\_  
*¿Qué idioma habló su hijo/hija cuándo aprendió a hablar?*
2. What language does your son/daughter speak most frequently at home? \_\_\_\_\_  
*¿Qué idioma habla su hijo/hija normalmente en casa?*
3. What language do you speak most frequently with your son/daughter? \_\_\_\_\_  
*¿Qué idioma habla usted con su hijo/hija??*
4. What language do the adults at home speak most often? \_\_\_\_\_  
*¿Qué idioma hablan los adultos en casa más a menudo?*

-----Proceed to signature if English is the only language spoken in your home-----  
-----Firme si el Inglés es el único idioma hablado en casa-----

5. On what date did your son/daughter enter the United States? \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
*¿En qué fecha entró su hijo/hija a Estados Unidos?*
6. On what date did your son/daughter enter a US School? \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
*¿En qué fecha entró su hijo/hija a una Escuela en EEUU?*
7. On what date did your son/daughter enter an Ohio school? \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
*¿En qué fecha entró su hijo/hija a una escuela en Ohio?*
8. What language do you prefer for communication from the school? \_\_\_\_\_  
*¿Qué idioma prefiere usted para comunicarse con la escuela?*

Name of available interpreter \_\_\_\_\_ Phone \_\_\_\_\_

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El nombre del intérprete disponible \_\_\_\_\_

Número de Teléfono \_\_\_\_\_

PARENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
Firma del Padre \_\_\_\_\_ Fecha \_\_\_\_\_

## MEDICAL STATEMENT

1. Based on his/her medical history and physical condition at the time of this examination, this child is free from apparent communicable disease and is in suitable condition for enrollment in a preschool program. *As required by Rules 5101:2-12-37 and 5101:2-13-37, the child must be examined within **thirteen months** prior to the date of admission.*

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Present Age: \_\_\_\_\_ Exam Date: \_\_\_\_\_

Sex:  M  F Height \_\_\_\_\_ Weight \_\_\_\_\_

Vision screening date \_\_\_\_\_ (if applicable) Hearing screening date \_\_\_\_\_ (if applicable)

2. This is to certify that I have examined this child and found that: This child has had the immunizations required by section 3313.571 of the Ohio Revised Code for admission to school, or has had the immunizations required by the state department of health according to the child's age, or is to be exempted from these requirements for medical or religious reasons. (Please provide documentation for exemptions.)

| IMMUNIZATION RECORD: (Enter month/day/year of each immunization) |       |     |         |          |
|--|-------|-----|---------|----------|
| DTP  | Polio | HIB | MMR     | HEP B    |
| 1.   | 1.    | 1.  | 1.      | 1.       |
| 2.   | 2.    | 2.  | 2.      | 2.       |
| 3.   | 3.    | 3.  |         | 3.       |
| 4.   | 4.    | 4.  | TB Test | Vercelli |
| 5.   |       |     | 1.      | 1.       |

Name of Physician (please print or stamp) \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_

Signature of Examining Physician \_\_\_\_\_ Date: \_\_\_\_\_

## DENTIST INFORMATION

Name of Dentist (please print) \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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Dear Parent/Guardians,

Please use this Credit Card Payment Authorization form if you would like to have your credit card charged automatically each month for your child's monthly preschool tuition. The first payment will be charged upon receipt of the form, the following payments will be charged on the **15<sup>th</sup>** of each month through **May 2020**. If you have any questions, please contact me at (440)350-2563 x 722 or by email at [jdowd@lakeesc.org](mailto:jdowd@lakeesc.org).

Completed forms may be mailed to Lake & Geauga Educational Service Centers, Attn: Jessica Dowd, 8221 Auburn Road, Concord, OH, 44077 or faxed to 440-352-6066.

Sincerely,

Jessica Dowd  
Billing Specialist

## Credit Card Payment Authorization (Please Print Clearly)

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|  |
|--|
| Date:  |
| Student Name:  |
| Preschool Attending:   |
| Cardholder's Name:   |
| Phone:   |
| MasterCard, Visa or Discover Card #:<br>_____                            |
| Expiration Date: _____ 3 Digit Security Number on Back of Card:<br>_____ |
| Amount to be charged monthly through May:<br>_____                       |
| Signature of Cardholder:<br>_____  |