LAKE COUNTY ESC PRESCHOOL PROGRAM

Please select preschool: □Perry □ Fairport □ Wickliffe

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

Documentation Required to Enroll Children in Preschool	
	All registration forms must be fully completed for each child
	Proof of Residency must be provided– see below-(copy) 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: ROXANNE

4261 MANCHESTER WEST (DOOR 15)

PERRY, OHIO 44081

440-354-7090

www.esc-lc.org

rprine@lakeesc.org

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ENROLLMENT FORM

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

The laws of the State of Ohio (Ohio Revised Coed 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	
☐ Mother ☐ Father ☐ Guardian ☐ Other	☐ Mother ☐ Father ☐ Guardian ☐ 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: ☐ Mother ☐ 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**

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: _____

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**

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**

LAKE COUNTY ESC PRESCHOOL PROGRAM

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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. _____

_____

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

LAKE COUNTY ESC PRESCHOOL PROGRAM

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

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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 idoma(s) que el estudiante hable para determinar la necesidad de ayuda para el desarrollo del idoma. 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 aprendio 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 _____
El nombre del intérprete disponible *Número de Teléfono*

PARENT'S SIGNATURE_____**DATE** _____
Firma del Padre ***Fecha***

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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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Tuition Information

- Tuition statements will be mailed approximately the 15th of each month beginning in September through May
- Child will be removed from the program if payment is not received in reasonable time
- Payment/ deposit (if applicable) can be made in the following ways:
    - Credit/ debit card by phone at 440-358-8044
    - Automatic withdrawal credit/ debit card by completing the form below and returning it to the address below *(preferred)*
    - Check payable to **Lake County ESC** mailed to address below

Auburn Career Center
Attn: Treasurer
8140 Auburn Road
Concord Ohio 44077

Lake County ESC Credit Card Authorization

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