



REGISTRATION PACKET

RICHMOND HEIGHTS LOCAL SCHOOL DISTRICT
447 Richmond Road
Richmond Heights, Ohio 44143
(216) 692-0086



RICHMOND HEIGHTS LOCAL SCHOOLS

447 RICHMOND RD. RICHMOND HTS., OHIO 44143 PHONE: 216-692-0086 FAX: 216-692-8487

"It's the Dawning of a New Day"

Welcome New Families and Partners in Education

We are so excited to welcome you to Spartan Nation and want to ensure that your child has a smooth transition to Richmond Heights Local Schools.

In order to meet that goal we will need ALL documents noted on the enrollment package. Therefore we strongly recommend you come prepared with all information to support a complete enrollment and a smooth transition. Upon a completed enrollment package, your child/children will begin school in 48 hours. This process is to allow the guidance counselor opportunity to schedule accordingly and the review of any documents that indicate exceptionalism and proper placement.

If you are unable to provide ALL documents at the time of enrollment, your child/children cannot begin school at Richmond Heights Local Schools until the registrar's office is in receipt of a complete enrollment package. Please refer to the enrollment package for the required documents.

If you have any questions of clarification, please feel free to contact me at askew.kelly@richmondheightsschools.org.

Thank you and Welcome to Spartan Nation,

Kelly Askew-Tucker

Kelly Askew-Tucker
Director of Educational Services
216-692-0086 ext.571228



RICHMOND HEIGHTS LOCAL SCHOOLS

447 RICHMOND RD. RICHMOND HTS. OHIO 44143 PHONE 216-692-7395 FAX 216-692-8487

PRESCHOOL REGISTRATION CHECKLIST

Parents, legal custodians or guardians must register their children **by appointment only** at the Board of Education Office. To schedule an appointment, please call **Ms. Bendes** at **(216) 692-7395**. In order for the registration process to move quickly, please use the checklist below and supply the district with the following documents:

1. ___ Completed **Registration forms** (attached).
2. ___ A current **Driver's License** or current **State ID** of the adult registering the student.
3. ___ **Original or certified copy of child's Birth Certificate.**
4. ___ **Child's Social Security Card.**
5. ___ **If applicable**, a stamped, certified copy of **Court Order establishing custody or guardianship.** (No photo copies)
6. ___ **Notarized residency affidavit** (form included in packet).
7. ___ **Lease, Mortgage, or Deed.** The district will not enroll without proof of residence.
8. ___ **Child's complete Immunization records** signed by your physician (form attached).

As the parent or legal guardian of the child being registered, you have a continuing responsibility to inform the superintendent of schools of any change of residence or legal custody. Regarding legal custody or guardianship, a court of jurisdiction must award it before a student will be allowed to enroll in the Richmond Heights Local School District.

The Richmond Heights Schools attendance officer will confirm the accuracy of information provided during the registration process by making home visits to all new students.

I have read the above enrollment procedures, understand them and will abide by them. I will notify the superintendent of schools of any changes that may occur.

Signature _____ Date _____



RICHMOND HEIGHTS LOCAL SCHOOL DISTRICT
RESIDENCY AND CUSTODY AFFIDAVIT



For the purpose of establishing school residence and custody (To be completed by parent or legal guardian)

SIGN ONLY AFTER CAREFULLY READING AND SIGNING IN THE PRESENCE OF A NOTARY

THE UNDERSIGNED, FIRST BEING DULY SWORN ACCORDING TO LAW, STATE THAT:

I, _____, certify that I am the custodial parent/legal guardian of _____
(Parent's or Legal Guardian's Full Name) (Student's Name)

and that I have established residency at _____
(Street Number, Name, Apt. #) (City) (State) (Zip Code)

Date of Occupancy: _____ Lease End Date (if applicable): _____

I, _____, certify that I am a resident of the above residence located within **Richmond Heights Local School District**. The registrar has explained to me that legal residency is determined by certain conditions, among them are that mail delivery, voting residence, and payroll city tax deductions are based on the **Richmond Heights Local School District** address and also, that the residence where meals are taken, and where the resident parent sleeps must be the **Richmond Heights Local School District/Richmond Heights** residence. (Photo identification, such as an Ohio Driver's License with your most recent address, is required for identification)

List the names of ALL people, both adults and children, who reside at the above address. Also, please indicate their school (if applicable) and "status" (i.e., homeowner, lessee, renter, parent, guardian, student, preschooler, grandparent, etc.) Attach a separate piece of paper, if needed.

Last Name	First Name	School (If Applicable)	Last Name	First Name	School (If Applicable)

Please read each statement and then place your initials to the left of the statement.

_____ I/we certify that the information provided in this document and registration packet is true and no information has been withheld, concealed, or misrepresented for the purpose of circumventing the school attendance laws of the State of Ohio in order to enroll named students in the **Richmond Heights Local School District**.

_____ I/we understand that I/we are responsible for informing school officials of any change(s) in the residence of any parent, legal guardian, or other responsible adult. If I change my present address to another address that is within the **Richmond Heights Local School District**, I will immediately file another residency and custody affidavit with the Board of Education of the **Richmond Heights Local School District**. I further understand that if the above noted address ceases to be my legal residence and my new residence is outside the boundaries of the **Richmond Heights Local School District**, I will withdraw my child(ren) from the district and will enroll my child(ren) in the new district of residence.

_____ I/we are also responsible for informing school officials of any changes to the legal custody or guardianship of the child(ren).

_____ I/we have provided the **Richmond Heights Local School District** with 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 children being enrolled as per Ohio Revised Code 3313.672.

_____ I/we acknowledge the student who is being registered has not been expelled or excluded from any other school pursuant to O.R.C. Sections 3301.121 and 3313.662.

_____ I/we understand that if the student attends school while not being eligible to do so tuition free, the student and all responsible parties will be liable for tuition at a rate set by the Ohio Department of Education according to the Ohio Revised Code 3317.08, and related costs, and the student will immediately be withdrawn from the **Richmond Heights Local School District**.

_____ I/we understand that the **Richmond Heights Local School District** may use whatever legal means it has at its disposal to verify my residency. I/we hereby waive my rights to confidentiality of information relative to my/our residence and give permission to the **Richmond Heights Local School District**, the City Tax Administrator, and the Regional Income Tax Agency (RITA) to release information such as name, social security number, and current and former addresses to confirm or deny my residency for the current or prior years.

_____ I give **Richmond Heights Local Schools** permission to discuss my Lease and/or Residency situation with my Landlord or Apartment Management Company.

_____ Be sure you have read this statement carefully before you initial. Giving false information under oath is punishable as a criminal offense under the Ohio Revised Code 2921.13 and 2921.21, a misdemeanor of the first degree with a maximum fine of \$1,000 and/or a jail term of six months. In cooperation with the City Prosecutors, each violation may be thoroughly and vigorously prosecuted.

Signature – MUST BE SIGNED IN FRONT OF A NOTARY IN ORDER TO BE NOTARIZED. DO NOT SIGN IN ADVANCE.

Parent/Legal Guardian/Custodian: _____

County of Cuyahoga)

)SS

State of Ohio)

Before me, a Notary Public of the State of Ohio, came the above-named who said that he/she/they did understand the statements set forth above and did adopt said statements and the information, herein as his/her/their own, as true to the best of his/her knowledge of the consequences and penalties of falsification, and did affix his/her signature in my presence,

This _____ day of _____, 20____

Notary Public _____



RICHMOND HEIGHTS LOCAL SCHOOL DISTRICT

STUDENT REGISTRATION FORM



Student Name	Last Name	First Name	Middle Name	Entry Grade
Social Security # (optional)	- -	Birth Date	Month / Day / Year	
Student Home Address	Number	Street	City	Zip Code Up <input type="checkbox"/> Down <input type="checkbox"/> Apt. #
Parent/Guardian	Name	Phone Number		
Previous school attended Include homeschooling	Name of School	School District	City	State

Is this student Hispanic/Latino? <input type="checkbox"/> No, not Hispanic/Latino <input type="checkbox"/> Yes, Hispanic/Latino	Race (choose one or more) <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander How Identified:
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Citizenship <input type="checkbox"/> Dual National <input type="checkbox"/> Non-Resident Alien <input type="checkbox"/> Resident Alien <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Other please name:
Birthplace City State Country	Native / Primary Language <input type="checkbox"/> English <input type="checkbox"/> Other please name:

Student Lives With (check all that apply) <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step-Parent <input type="checkbox"/> Other (explain):	<input type="checkbox"/> Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Self
Legal Custody (check all that apply) <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Foster Parent Court Journal Entry: (/ /) County: _____ District Bearing Cost(for Foster Children only):	<input type="checkbox"/> Guardian <input type="checkbox"/> CDCFS <input type="checkbox"/> Other (explain): <input type="checkbox"/> Probate Court <input type="checkbox"/> Juvenile Court Restrictions: _____

Is the child in gifted or Advanced Placement?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, describe services:
Does the child have a 504 plan?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, describe services:
Has the child ever had an IEP?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, list year of most recent evaluation:
If yes, do you have a copy of the IEP?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, indicate program:
Is the child suspended?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, from what district?
Is the child expelled?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, from what district? End Date:

☐ I do not consent to the release of email, home address, and home phone number for outreach purposes

Daycare/Preschool/Kindergarten Questionnaire

Has your child been in a previous school setting: ☐ Yes ☐ No

If so, please name school(s): _____ Address _____

City _____ State _____ Phone Number _____

Permission to Contact: ☐ Yes ☐ No

Parent/Guardian Signature: _____ Date: _____

PARENT(S) / GUARDIAN INFORMATION**STUDENT NAME:****Mother** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Remarried ☐ Deceased☐ Residential ☐ Non-Residential
Dual Mailing: ☐ Yes ☐ No

Last Name

First Name

Address Number Street City Zip Code

Workplace Email

Home Phone Work Phone Cellular Phone

Father ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Remarried ☐ Deceased☐ Residential ☐ Non-Residential
Dual Mailing: ☐ Yes ☐ No

Last Name

First Name

Address Number Street City Zip Code

Workplace Email

Home Phone Work Phone Cellular Phone

☐ Legal Guardian ☐ Step Parent ☐ Foster Parent ☐ Other:

Last Name First Name

Address Number Street City Zip Code

Workplace Email

Home Phone Work Phone Cellular Phone

Social Worker (If Applicable):

☐ Legal Guardian ☐ Step Parent ☐ Foster Parent ☐ Other:

Last Name First Name

Address Number Street City Zip Code

Workplace Email

Home Phone Work Phone Cellular Phone

Social Worker (If Applicable):

EMERGENCY CONTACT INFORMATION

Name	Relationship	Name	Relationship
Telephone		Telephone	
Address		Address	
Email		Email	

PLEASE LIST ALL OTHER CHILDREN UNDER THE AGE OF 22 WHO LIVE AT THE HOME ADDRESS

Name	Grade	Date of Birth	Gender	Relationship To Student

I hereby certify, under penalty of perjury, that all of the information that I have given is correct in all respects to the best of my knowledge.

Date: _____ Parent/Legal Guardian/Independent Student: _____

Date: _____ Information Verified By: _____

Signature



Richmond Heights Local Schools

Emergency Medical Authorization

To enable parents and guardians to provide necessary information and to authorize the provision of emergency treatment for a student who becomes ill or is injured while under school authority.

Student Name _____
Last First Middle Birth Date
Home Address _____ Apt. _____
Primary Phone () _____ E-mail _____

Parent(s) or Guardian with whom student lives:

Name / Relation to student / Name / Relation to student
Cell Phone () _____ Cell Phone () _____
Daytime () _____ Daytime () _____

Non-Residential Parent (If Applicable)

Name / Relationship to Student Primary Phone

Address Apt. City State Zip Code

Is there a court order which limits / prohibits non-custodial parent contact? ☐ Yes ☐ No
If yes is marked, parent must contact the office and provide legal documentation.

Transportation

Check all that applies: Bus to school _____ Bus from school _____ Car rider _____ Walk _____

* If your child does not go home after school, please list where the child goes, on what days, and phone number:

Name / Agency () Phone Number M T W T H F
Circle Days

Note: Requests to change normal transportation MUST be made in writing.

List the person(s) who will care for your child in the event that reasonable attempts to contact parent(s) have been unsuccessful. List contacts in the order in which you prefer them to be called.

1. _____ () _____
Name / Relationship to Student Primary Phone
2. _____ () _____
Name / Relationship to Student Primary Phone
3. _____ () _____
Name / Relationship to Student Primary Phone

Please include name of an older sibling who is authorized to pick up student in the event of a disaster.

Grade _____

Information Concerning Student's Health – Please print

Medical History: _____

Allergies (insect, food, medications, etc.): _____

Physical impairments that limit mobility: _____

Medications taken (including dosage and times given): _____

****Please note: If your child would need to take any medication during a 24-hour period of "sheltering in place", please contact the school nurse to discuss this matter confidentially.**

Describe any **critical medical information** the bus driver should be aware of when transporting this student:

To Grant Consent

☒ **I grant consent**, in the event that reasonable attempts to contact me have been unsuccessful, (1) for the administration of any treatment deemed necessary by the named doctors:

Dr. _____ Phone Number (____) _____
Preferred Physician

Dr. _____ Phone Number (____) _____
Preferred Dentist

or in the event the designated preferred practitioner is not available, by another licensed physician or dentist.

(2) the transfer of the child to (preferred hospital) _____, or 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 Parent / Guardian

Date

Refusal to Grant Consent

☒ **I refuse to grant consent** for emergency medical treatment of my child. In the event of illness or injury requiring medical treatment, I wish the school authorities to take the following action:

Signature of Parent / Guardian

Date

I understand that I am responsible for keeping ALL information current and correct.



Department
of Education

Office of Early Learning and School Readiness
Child Medical Statement

Revised 3/12/2018

This form meets Ohio Administrative Code. Programs may use this form or build their own.

Section I - Child Medical Information

Child's Name _____

Date of Birth _____ Height _____ Weight _____

Immunizations:		Exempt from Immunization:	
Complete for Age	<input type="radio"/> Yes <input type="radio"/> No	Religious Conviction	<input type="radio"/> Yes <input type="radio"/> No
In Process	<input type="radio"/> Yes <input type="radio"/> No	Health	<input type="radio"/> Yes <input type="radio"/> No
		Other	_____

Limitations or health conditions, including allergies, medications, and dietary restrictions.

Section II - Child Medical Statement Verification

Physician/Clinic/Hospital Name _____ Provider Address _____

Provider Phone Number _____ Provider City _____ Provider State _____ Provider Zip _____

Check box of examining medical professional:

- ☐ Physician
☐ Physician Assistant
☐ Advanced Practice Registered Nurse

This child has been examined and is in suitable condition to participate in group care.

Signature of Medical Professional _____ Date of Exam _____

Programs funded through the Ohio Department of Education must have written policies and procedures to ensure that children have received comprehensive health screenings and/or that families are informed of the importance of health screenings and the resources to obtain them.

Ohio Department of Health School and Adolescent Health Immunization Report

Student's Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
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Students are required to be immunized in accordance with Ohio law (Ohio Revised Code 3313.67/3313.671). A copy of the child's immunization record may be attached or dates may be entered below. Please note the month, day and year for each immunization should be on record.

Vaccine	Record complete dates (month, day, year) of vaccine doses given
Diphtheria, Tetanus, Pertussis (DTap,DT, Tdap, Td)	
Polio	
Hepatitis B (HBV)	
Measles, Mumps, Rubella (MMR)	
Varicella (Chicken pox)	
Hepatitis A	
Meningococcal (MCV4)	
Pneumococcal (PCV)	
Measles (Rubeola) only	
Rubella only	
Mumps only	
Haemophilus influenza Type b (Hib)	
Influenza	
Other	

This information was provided by ☐ Health Care Provider ☐ Parent/Guardian ☐ Other _____

Signature	Print Name	Date / /
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Appendix A: Language Usage Survey

Parents and Guardians: Please only complete this page of the survey. The back of this form will be completed by the school. A completed language usage survey is required for all students upon enrollment in Ohio schools. This information will tell school staff if they need to check your child's proficiency in English. Answers to these questions ensure your child receives the education services to succeed in school. The information is not used to identify immigration status.

Student Name: (First Name and Last Name) _____		Student Date of Birth: (mm/dd/yyyy) _____
Communication Preferences Indicate your language preference so we can provide an interpreter or translated documents at no cost when you need them. All parents have the right to information about their child's education in a language they understand.	1. In what language(s) would your family prefer to communicate with the school? _____	
Language Background Information about your child's language background helps us identify students who qualify for support to develop the language skills necessary for success in school. Testing may be necessary to determine if language supports are needed.	2. What language did your child learn first? _____ 3. What language does your child use the most at home? _____ 4. What languages are used in your home? _____	
Prior Education Responses about your child's birth country and previous education give us information about the knowledge and skills your child is bringing to school and may enable the school to receive additional funding to support your child.	5. In what country was your child born? _____ 6. Has your child ever received formal education outside of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many years/months? _____ If yes, what was the language of instruction? _____ 7. Has your child attended school in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when did your child first attend a school in the United States? _____ / _____ / _____ Month Day Year	
Additional Information Please share additional information to help us understand your child's language experiences and educational background.	_____	
Parent/Guardian First Name: _____		Parent/Guardian Last Name: _____
Parent/Guardian Signature: _____		Today's Date: (mm/dd/yyyy) _____

Thank you for providing the information above. Contact your school or district office if you have questions about this form or about services available at your child's school. Translated information about schools' civil rights obligations to English learner students and limited English proficient parents can be found here: <https://www2.ed.gov/about/offices/list/ocr/ellresources.html>





Richmond Heights Local Schools

Prepare individual learners to navigate an evolving global community using 21st century competencies.

Richmond Heights School District Preschool Program

As required by the Preschool Program Rules, each year our program must prepare a roster for each group of children. This roster will not be furnished to any persons other than parents of children enrolled in the program.

Please authorize the following to be listed on the parent roster.

My child's name	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Family name	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Phone Numbers	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Student

Signature of parent/guardian



Richmond Heights Local Schools

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POLICY AGREEMENT FORM

Please read and complete all sections, sign and return to your child's homeroom teacher.

1. Receipt of the Student Code of Conduct:

- ☐ I have received a copy of the Richmond Heights Student Code of Conduct contained within the Student Handbook and reviewed this information with my child.
- ☐ I have not received a copy of the Richmond Heights Student Code of Conduct or the Student Handbook.

2. Media Release:

☐ Permission granted ☐ Permission denied*

Photographs, voice recordings and videos of students participating in activities at school may appear in media such as newsletters, newspapers, the Richmond Heights Schools' web site, brochures, or other publicity materials. Please indicate whether you grant permission for the use of photos, recordings and videos in such media formats.

*Please be advised that if you decide to deny permission for media release of your child's image or voice, it does not include incidental images or voice recordings captured at athletic or school events taken by a third party.

3. Field Trips:

☐ Permission granted ☐ Permission denied

My child has permission to participate in school experiences outside the school building and grounds such as field trips. I understand that I will be informed in advance of the dates, times, and locations of any planned activity or field experience. I further understand that I may be required to complete permission slip forms for individual field trips during the school year.

4. Computer Acceptable Use Policy – Student User Agreement:

As a student user of the Richmond Heights Local Schools computer network, I agree to comply with district policy 7540.03 (found on the Richmond Heights Schools web site under Forms and Links and "Bylaws and Policies"), which states the rules for communicating over the network in a reliable fashion while honoring all relevant laws and restrictions.

Student Name (please print) _____ Grade Level _____

Student Signature: _____ Teacher: _____

5. Computer Acceptable Use Policy -

Parent Permission:

☐ Permission granted

☐ Permission denied

As a parent or legal guardian of the minor student signing on the previous page, I grant permission for my son or daughter to access networked computer services such as electronic mail and the Internet. Teachers, staff and students are instructed to use educationally appropriate speech and expression when using the Internet and other technological tools. I understand, however, that I am responsible for setting and conveying the standards that my child/children should follow when using the Internet. I also understand that there is no guarantee or expectation of privacy when using school-owned computers. Some materials on the Internet may be objectionable, and not authorized by the School Board for educational purposes, but I assume risks by consenting to allow my child to participate in the use of the Internet. In addition, I understand that emails and any responses to it will be archived for later retrieval and may constitute a public record and therefore may be made available upon request in accordance with Ohio Public Records law (ORC 149.43).

6. Permission for district, school and teachers to use email to communicate with parents about students and other district information:

☐ Permission granted

☐ Permission denied

I grant permission to use email as a means of communication for the district, school, and my child's teachers.

Parent email (please print carefully):

My child ☐ has access to this email account. ☐ does not have access to this email account.

I have read each section of this Policy Agreement Form and have indicated in each section whether I grant or deny permission.

Parent Name (please print): _____

Parent Signature: _____

Address: _____

Primary Phone: _____ **Date:** _____

Please sign and return this form to your child's teacher.



Richmond Heights Local Schools

Prepare individual learners to navigate an evolving global community using 21st century competencies.

Child release Form

Even though transportation is provided by the school district, there may be a time when your child will need other means of transportation. If one of the individuals below must transport your children, please have them bring identification.

I, parent/guardian of _____ give permission for the following person or persons to transport my child.

_____ Name of person	_____ Relationship to child
-------------------------	--------------------------------

_____ Name of person	_____ Relationship to child
-------------------------	--------------------------------

_____ Name of person	_____ Relationship to child
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Signature of parent/guardian

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

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

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

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

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

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

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

What causes your child to feel angry or frustrated?

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

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

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

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

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

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

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

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

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

Does your child have trouble sleeping (Night terrors, trouble going to sleep, etc.)? Please explain.

What might you and/or your child be anxious about as he/she starts in this program?

What are you and/or your child excited about as he/she starts in this program?

What are your expectations of this program?

What other information would be helpful for the staff caring for your child to know?

Parent/Guardian's Signature

Date

Ohio Department of Job and Family Services
Ohio Department of Education
EARLY CHILDHOOD EDUCATION ELIGIBILITY SCREENING TOOL

How do I apply for Early Childhood Education Services (ECE)?

- Complete the screening tool, JFS 01121.
- Submit this form to **your provider**.
- **Do not** submit the form to the Ohio Department of Education.
- Your provider will let you know if you qualify.

How do I apply for Publicly Funded Child Care?

- Complete the screening tool, JFS 01121, and the JFS 01122 Publicly Funded Child Care Supplemental Application, answering as many questions as you can. **Be sure to sign both forms.**
- Submit both the JFS 01121 and JFS 01122 to your local county agency.
- Attach verifications to the JFS 01122 (see verification requirements below).
- A verifications checklist will be mailed to you within 10 days of your application date if more information is needed to make a decision on your case.
- **You will have 30 days** from the date the county receives your application to provide all needed information.

What verifications do I need for publicly funded child care?

- **Proof of income:** Verification of income includes but is not limited to paystubs, tax records, award letters, child support orders, etc.
- **Proof of any child support paid.**
- **Proof of citizenship or qualified alien status for children in need of care:** If the county agency verifies that you have already provided proof of citizenship to qualify for OWF, you will not have to provide it a second time.
- **Proof of a qualifying activity for all caretakers in the household:** Verification of a qualifying activity includes but is not limited to an official school schedule, work schedule, employment verification, self-sufficiency contract, etc.
- **Provide the name and address of an eligible child care provider chosen for each child in need of care. (See below for tips on choosing a provider).**

What is Step Up To Quality?

Step Up To Quality helps families identify child care programs that go beyond the minimum standards of licensing. **Star rated programs demonstrate higher levels of quality in a variety of ways. For more information, visit the ODJFS child care website at <http://ifs.ohio.gov/cdc/index.stm> and click on "Step Up To Quality."**

How do I choose a Provider?

ECE: If you would like to view a map of early childhood education providers, visit <http://education.ohio.gov/Topics/Early-Learning/Early-Childhood-Education-Grant>.

Publicly Funded Child Care: Parents may select any program approved to offer publicly funded child care. These programs include centers, family child care homes and in-home aides located throughout the state of Ohio.

- If you would like assistance with selecting a publicly funded child care provider, you may contact your local Child Care Resource and Referral Agency. Visit <http://ifs.ohio.gov/cdc/families.stm> for contact information.
- You may use the ODJFS Child Care Directory to look for programs that fit your child care needs at <http://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.

Continued on next page

When will my eligibility begin?

ECE: You will be notified by your provider when you may begin care.

Publicly Funded Child Care: Your eligibility for the publicly funded child care program is determined within 30 days from the date the signed application is received by the county. If this application is approved and you are eligible for child care benefits, the county agency may authorize payment for child care from the date the county received this application.

How do I get help with completing this application?

ECE: If you need assistance with this application, ask your provider.

Publicly Funded Child Care: If English is not your primary language, the county agency will provide someone who can help you understand the questions on this application. If you have a disability, are hearing impaired or visually impaired, the county agency will help you complete this application.

What if my child has a disability or I suspect my child may be developmentally delayed?

- To learn more about Medicaid health screenings and early intervention services for your child, please visit the Ohio Department of Job and Family Services child care website at <http://jfs.ohio.gov/CDC/childcare.stm> and click on "Families."
- **Publicly Funded Child Care:** Your child care provider may qualify for additional assistance if they must make special adaptations for your child. Your provider may contact your county agency for more information.

How do I make a complaint about a provider?

ECE (ODE): If the program is licensed by ODE, call 614-466-0224.

Publicly Funded Child Care (ODJFS): If the program is licensed by ODJFS, call 1-877-302-2347, option 4

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 <small>(First, Middle, Last)</small>	Relationship to You <small>(spouse, son, friend, etc.)</small>	Race	Hispanic or Latino <small>Y or N</small>	Spoken Language	Date of Birth	Gender <small>M or F</small>	U.S. Citizen <small>Y or N</small>
	Self	<input type="checkbox"/> African American <input type="checkbox"/> Alaska Native/American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hawaiian/Pacific Islander					
		<input type="checkbox"/> African American <input type="checkbox"/> Alaska Native/American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hawaiian/Pacific Islander					
		<input type="checkbox"/> African American <input type="checkbox"/> Alaska Native/American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hawaiian/Pacific Islander					
		<input type="checkbox"/> African American <input type="checkbox"/> Alaska Native/American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hawaiian/Pacific Islander					
		<input type="checkbox"/> African American <input type="checkbox"/> Alaska Native/American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hawaiian/Pacific Islander					

Child 1	Provider Name and Address	What hours/days do you need services? (i.e. child care or preschool) <i>Check all that apply</i>
Name		<input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Mornings <input type="checkbox"/> Afternoons <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends
Child's Mother's Maiden Name		What is the child's home school district?
Child's City of Birth		
Special Needs Is your child in need of special needs child care based on this definition? "Special needs child care" means child care provided to a child who is less than eighteen years of age and either has one or more chronic health conditions or does not meet age appropriate expectations in one or more areas of development, including social, emotional, cognitive, communicative, perceptual, motor, physical, and behavioral development and that may include on a regular basis such services, adaptations, modifications, or adjustments needed to assist in the child's function or development. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Child 2	Provider Name and Address	What hours/days do you need services? (child care or preschool) <i>Check all that apply</i>
Name		<input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Mornings <input type="checkbox"/> Afternoons <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends
Child's Mother's Maiden Name		What is the child's home school district?
Child's City of Birth		
Special Needs Is your child in need of special needs child care based on this definition? "Special needs child care" means child care provided to a child who is less than eighteen years of age and either has one or more chronic health conditions or does not meet age appropriate expectations in one or more areas of development, including social, emotional, cognitive, communicative, perceptual, motor, physical, and behavioral development and that may include on a regular basis such services, adaptations, modifications, or adjustments needed to assist in the child's function or development. <input type="checkbox"/> Yes <input type="checkbox"/> No		

Child 3	Provider Name and Address	What hours/days do you need services? (child care or preschool) <i>Check all that apply</i>
Name		<input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Mornings <input type="checkbox"/> Afternoons <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends
Child's Mother's Maiden Name		What is the child's home school district?
Child's City of Birth		
Special Needs <p>Is your child in need of special needs child care based on this definition? "Special needs child care" means child care provided to a child who is less than eighteen years of age and either has one or more chronic health conditions or does not meet age appropriate expectations in one or more areas of development, including social, emotional, cognitive, communicative, perceptual, motor, physical, and behavioral development and that may include on a regular basis such services, adaptations, modifications, or adjustments needed to assist in the child's function or development.</p> <input type="checkbox"/> Yes <input type="checkbox"/> No		

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)
					<input type="checkbox"/> Sun _____ <input type="checkbox"/> Thurs _____ <input type="checkbox"/> Mon _____ <input type="checkbox"/> Fri _____ <input type="checkbox"/> Tues _____ <input type="checkbox"/> Sat _____ <input type="checkbox"/> Wed _____
					<input type="checkbox"/> Sun _____ <input type="checkbox"/> Thurs _____ <input type="checkbox"/> Mon _____ <input type="checkbox"/> Fri _____ <input type="checkbox"/> Tues _____ <input type="checkbox"/> Sat _____ <input type="checkbox"/> Wed _____
					<input type="checkbox"/> Sun _____ <input type="checkbox"/> Thurs _____ <input type="checkbox"/> Mon _____ <input type="checkbox"/> Fri _____ <input type="checkbox"/> Tues _____ <input type="checkbox"/> Sat _____ <input type="checkbox"/> Wed _____
					<input type="checkbox"/> Sun _____ <input type="checkbox"/> Thurs _____ <input type="checkbox"/> Mon _____ <input type="checkbox"/> Fri _____ <input type="checkbox"/> Tues _____ <input type="checkbox"/> Sat _____ <input type="checkbox"/> Wed _____
					<input type="checkbox"/> Sun _____ <input type="checkbox"/> Thurs _____ <input type="checkbox"/> Mon _____ <input type="checkbox"/> Fri _____ <input type="checkbox"/> Tues _____ <input type="checkbox"/> Sat _____ <input type="checkbox"/> Wed _____

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

How Much?

Signature of Applicant

Date



Richmond Heights Local Schools

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Medical Services (Immunizations, Lead Screening, Well Child Visits)

Name	Address	Phone Number	Payment Method
Cleveland Department of Public Health Services: <i>Immunizations and Lead Screening(must make apt in advance) Reproductive health screenings</i>	The City of Cleveland Health Centers: •J. Glen Smith Health Center-11100 St. Clair Ave., Cleveland, OH 44108 •Thomas F. McCafferty Health Center - 4242 Lorain Ave., Cleveland, OH 44113 Lead Safe Living Hotline	216-664-7095 216-664-6603 216-263-5323	Private insurance; Sliding fee scale. If no insurance, patients are referred for enrollment in Medicaid or Marketplace
Cuyahoga County Board of Health Services: <i>Immunizations and Lead Screening</i>	5550 Venture Rd., Parma, OH 44130	216-201-2041	Medicaid accepted Call for an appointment and information regarding non-Medicaid payment options (Lead screening once a month by appointment)
Northeast Ohio Neighborhood Health Services, Inc. Services: <i>Dental Immunizations Lead Screening</i> Provides all medical services (functions as a medical home)	•East Cleveland Health Center-15201 Euclid Ave., East Cleveland, OH 44112 •Superior Health Center-12100 Superior Ave., Cleveland, OH 44106 •Southeast Health Center-13301 Miles Ave., Cleveland, OH 44105 •Norwood Health Center-1468 E. 55 th St., Cleveland, OH 44103 •Hough Health Center-8300 Hough Ave., Cleveland, OH 44103 •Collinwood Health Center-15322 St. Clair Ave., Cleveland, OH 44110 • Miles/Broadway Health Center-9127 Miles Ave., Cleveland, OH 44105	216-541-5600 216-851-2600 216-751-3100 216-881-2000 216-231-7700 216-851-1500 216-664-6544	Medicaid; private insurance and has a discounted fee structure based on family size and income (No dental at Miles/Broadway) *Central Intake 216-231-7700, press 2 for pediatrics
Care Alliance Health Care Services: <i>Dental, Immunizations, Lead Screening</i> Provides all medical services (functions as a medical home)	•Central Neighborhood Clinic-2916 Central Ave. Cleveland, OH 44115 •St. Clair Clinic- 1530 St. Clair Ave. Cleveland, OH 44144 •Riverview Tower Clinic-1795 W. 25 th St., Cleveland, OH 44113 •Carl B. Stokes Clinic- 6001 Woodland Ave., 2 nd Floor, Cleveland, OH 44104	216-535-9100 216-781-6724 216-619-5571 216-923-5000	Medicaid and Sliding scale



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Pediatric Dental

Provider Name	Address	Phone Number	Payment Method
CWRU School of Dental Medicine Early Childhood Dental Program*	2124 Cornell Rd., Cleveland, OH 44106	216-368-0665	Medicaid; Private insurance needs to be paid at point of service with patient submitting to insurance
Tapper Dental Center at University Hospitals	Rainbow Babies and Children's Hospital 1100 Euclid Ave., Cleveland, OH 44106	216-844-3080	Medicaid and Private Insurance
Tri-C's Dental Hygiene Clinic <i>Preventative Treatment Only</i>	2900 Community College Ave., MetroHealth Careers and School (MHCS), Rm.127, Cleveland, OH 441155	216-987-4413 Call for an appointment	Cash or check only; No insurance accepted \$10- Children 17 yrs. and younger; \$15- ages 18 and up
MetroHealth Medical Center	<ul style="list-style-type: none"> •Main Campus- Dental Clinic, 2500 MetroHealth Dr., Cleveland, OH 44109 •Lee-Harvard Clinic- 4071 Lee Rd., Ste.260, Cleveland, OH 44128 •Old Brooklyn Campus-4229 Pearl Rd., Cleveland OH 44109 •Broadway Health Center- 6835 Broadway Ave., Cleveland, OH 44105 	216-778-4725 216-957-1222 216-957-1850 216-957-1850	Medicaid; Private insurance; Sliding fee scale
Northeast Ohio Neighborhood Health Services, Inc.	(NEON does provide pediatric dental services- details above)		
Care Alliance Health Care	(Care Alliance does provide pediatric dental services -details above)		

Name	Address	Phone Number	Payment Method
Cleveland Hearing & Speech Center	<ul style="list-style-type: none"> •11635 Euclid Ave., Cleveland, OH 44106 •4257 Mayfield Rd., S. Euclid, OH 44121 •7000 Town Dr.#200, Broadview Hts., OH 44147 •29540 Center Ridge Rd., Westlake, OH 44145 	216-231-8787 216-382-4520 440-838-1477 440-455-9898	Medicaid; Private Insurance; Sliding fee scale
Prevent Blindness Ohio- Northeast OH Chapter* (trains providers on how to screen)	Hillcrest Medical Building#1- 6803 Mayfield Rd., Suite 111, Cleveland, OH 44124	800-331-2020 Or 440-720-1285	**does not provide vision screening to individuals; works with centers
Easter Seals Northern Ohio (speech, hearing, and vision)	<ul style="list-style-type: none"> •1929 A East Royalton Rd., Broadview Hts., OH 44147** •14701 Detroit Ave., Lakewood, OH 44107 	440-838-0990 **Central Intake phone #	Medicaid; Private Insurance; Sliding fee scale
St. Luke's Dental Practice	1201 Shaker Blvd. Cleveland, OH 44104	216-368-7238 Call for an appointment	Medicaid; Private Insurance; Sliding fee scale

Hearing, Speech & Vision

* Resources that will train staff and/or come to your location to conduct tests and screenings on children
Please remember to call 2-1-1 for additional information on resources available in Cuyahoga County.
Please call providers listed above for additional information.



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Know what your child's blood lead test results means:

Lead can cause problems with learning, hearing, speech and behavior.

What should I do if I think there is lead in my home?	Contact your local health department to schedule an inspection right away! (see the helpful numbers and websites at the bottom of this page)
Avoid dry dusting or sweeping. Wet mop all floors and window sills.	Make sure your children wash their hands often.
Plant grass to cover bare dirt in the yard. Wash toys when they have been on the ground.	Duct tape over any cracking or peeling paint until a qualified professional removes repairs or covers the lead paint.

What do the lead levels mean and what should I do if my child shows an elevated lead level?	
Blood Lead Value 0-4	<ul style="list-style-type: none"> Your child should be tested for lead once a year until they turn 6 years old. Lead levels less than 5 mean there is low level lead exposure Call your health department to learn more about lead and how to make your home lead safe.
5-9	<ul style="list-style-type: none"> Your child will need a blood test every 2-3 months until the level is less than 5. Schedule this follow-up testing with your doctor's office. A case manager will call or send you a letter with advice about your child's lead level. The other children under 6 years old in your home need to be tested also.
10-19	<ul style="list-style-type: none"> Your child will need a blood test in 1-2 months, and then repeat testing until the number is less than 5. Schedule this follow-up testing with your doctor's office. A case manager from the health department will call to talk about your child's lead level and help you learn more about lead. The health department will want to check your home for lead.
20-44	<ul style="list-style-type: none"> Your child will need a blood test in 2-4 weeks, and then repeat testing until the number is less than 5. Schedule this follow-up testing with your doctor's office. A case manager from the health department will talk to you by phone to let you know what to do for your child. Your home may be checked for lead by the health department.
45 or Higher	<ul style="list-style-type: none"> YOUR CHILD MUST GO SEE A DOCTOR OR GO TO THE HOSPITAL TODAY. Your child must be treated with a special medicine to help lower their lead level. Repeat testing 3-4 weeks after treatment. Re-treatment may be necessary. Your home must be checked for lead by the health department as soon as possible. A case manager from the health department can visit your home or talk to you by phone to let you know what to do for your child.

Rainbow Babies and Children's Hospital - www.Rainbow.org/lead

Telephone: 216-844-LEAD (5323)

Cuyahoga County Board of Health Child Lead Poisoning and Prevention Program - <http://www.ccbh.net/lead-poisoning>

Telephone: 216-201-2000 ext. 1215

Cleveland Division of Public Health Lead Safe Living - http://www.clevelandhealth.org/network/environment/lead_safe_living.php

Telephone: 216-263-5323

City of Cleveland Lead Hazard Control Program -

<http://www.city.cleveland.oh.us/CityofCleveland/Home/Government/CityAgencies/CommunityDevelopment/DivisionofNeighborhoodServices/LeadHazardControlProgram>

Telephone: 216-263-5323

Ohio Department of Health Lead Poisoning Prevention Program - https://www.odh.ohio.gov/odhprograms/eh/lead_ch/leadch1.aspx

Telephone: 1-877-LEADSAFE (532-3723)

United States Environmental Protection Agency (EPA) - <https://www.epa.gov/lead>

Centers for Disease Control and Prevention (CDC) - <http://www.cdc.gov/nceh/lead>



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Pre-K/Preschool Health Screening Acknowledgement Form

Dear Parent(s)/Caregiver,

As part of the Pre-Kindergarten program your child must have certain health screenings. These screenings may help prevent future problems with your child's health. Some of these screenings may be offered by your child's pediatrician. If not, a list of resources is attached for those screenings that may not be provided by your child's preschool.

Thank you!

Below is a list of required screenings

- ❖ Lead screening
- ❖ Hematocrit/Hemoglobin screening
- ❖ Dental screening
- ❖ Vision screening
- ❖ Hearing screening

Your signature below verifies that you are aware of the medical screenings your child needs; confirms that you received the necessary forms for your doctor or dentist to complete; and confirms that you received the list of local resources available to assist you with completing the medical screenings.

Child's Name

Parent/Caretaker

Teacher

Date

Date

Original to Parent

Copy to Child's File

MANAGEMENT OF COMMUNICABLE DISEASES

If your child is ill when at home, do NOT send him/her to school. It is not fair to expose other children to disease; neither will your child benefit from the experience. We are not equipped to handle sick children, and you will be asked to pick them up immediately.

Should your child become ill while at the school, we will isolate him/her from the rest of the children and make him/her as comfortable as possible. We will contact you to pick up your child as soon as possible. Remember, if someone other than the registering parent will be picking up a child, staff members will require identification and your prior notice, preferably in writing.

Your child will be isolated and discharged to you immediately if these symptoms appear:

1. diarrhea more than once
2. severe coughing
3. difficult or rapid breathing
4. yellowish skin or eyes
5. tearing, inflamed eyes
6. temperature of 100 degrees Fahrenheit when taken by auxiliary method
7. untreated skin rash
8. dark urine or light stool
9. stiff neck
10. unusual spots
11. sore throat
12. vomiting
13. evidence of lice

Children who have fevers, vomiting and diarrhea should not return to school for 24 hours. Children on antibiotics should remain at home until they have been receiving medication for 24 hours.

Every effort will be made to avoid transmitting illness within the classroom. All preschool staff members will wash their hands with soap and running water after each diaper change, or after assisting a child with toileting; after cleaning; before preparing or eating food, after toileting; before feeding any child; and when hands have been in contact with nasal or mucous secretions. Disposable towels or an air hand dryer will be available at all times.

BEHAVIOR AND GUIDANCE MANAGEMENT POLICY

Children will be treated with respect, concern for their dignity and enhancement of their self-concept. The following believes underline our behavior management policy:

Development of self-discipline, decision-making and problem solving skills are the goals of our behavior-management policy. All techniques will be directed toward helping children take responsibility and develop an understanding of their own behavior.

We recognize that while children are learning self-control, they need to be protected from hurting themselves, others and destroying property. The following are some of the techniques used in behavior management with an emphasis on prevention.

- establish a positive relationship with the child
- arrange a safe, healthy and highly structured learning environment
- be an appropriate model
- implement problem solving skills taking into consideration developmental appropriateness
- define the limits or rules in positive manner and appropriate manner
- anticipate potential problems
- develop an effective communication (expressive/receptive) based on each students level of functioning
- encourage and praise
- observe and record (when designated)/develop and consistently follow a behavioral plan
- offer verbal and/or visual suggestions, questions, gestures at the right time (respecting the need for autonomy ad independence)
- guide children to make appropriate decisions and choices
- be proactive, anticipate behaviors and redirect the child when necessary
- allow natural and logical consequences within safety limits, be flexible and maintain a sense of humor

We also realize that children may at times, need more structured behavior management to reduce inappropriate behaviors. When those situations occur, the following techniques are used:

- behavior plans will be individualized to fit each students needs
- specific behavior plan will be developed and shared with families prior to implementation
- physically guiding/moving or redirecting a child to prevent injury to self, others and/or property

The center's actual method of discipline shall apply to all persons on the premises and shall be restricted as follows:

1. There shall be no cruel, harsh, corporal punishment or any unusual punishments such as, but limited to, punching, pinching, shaking, spanking or biting.
2. No discipline shall be delegated to any other child.
3. No physical restraints shall be used to confine a child by any means other than holding a child for a short period of time, such as in a protective hug, so the child may regain control.
4. No child shall be placed in a locked room or confined in an enclosed area such as a closet, a box or a similar cubicle.
5. No child shall be subjected to profane language, threats, derogatory remarks about himself or his family or other verbal abuse.
6. Discipline shall not be imposed on a child for failure to eat, failure to sleep, or for toileting accidents.
7. Techniques of discipline shall not humiliate shame or frighten a child.
8. Discipline shall not include withholding food, rest or toilet use.
9. Separation, when used as discipline shall be brief in duration and appropriate to the child's age and developmental ability and the child shall be within sight and hearing of a preschool staff member in a safe, lighted and well-ventilated space.
10. The center shall not abuse or neglect children and shall protect children from abuse and neglect while in attendance in the preschool program.