Clark Early Learning Center

Preschool Information Documents

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Clark Early Learning Center Enrollment Form

☐ **New Enrollment** to our Preschool **OR** ☐ **Returning** from last school year

Student Name _____ ☐ Male ☐ Female

Date of Birth _____ Age as of 8/1: ☐ 3 years-old ☐ 4 years-old

Parent/Guardian _____

Address _____

Email Address _____ Home Phone _____

Cell Phone _____ Work Phone _____

Teacher Preference _____

Toilet Trained: ☐ Yes ☐ No

Do you have any areas of concern about your child? _____

_____

Parent(s)/Guardian(s) are you an employee of Springfield City School District? ☐ Yes ☐ No

If yes, please state position and location: _____

FOR OFFICE USE ONLY

Classroom Assignment _____

Session Assignment: ☐ AM ☐ PM ☐ Ext. Day ☐ Full Day

Elementary/Middle School Area: _____

ITEMS TO FILL OUT IN THIS PACKET

☐ Child Enrollment Form

☐ Health History Form

☐ Grant Screening Tool

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Child Enrollment Information

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

Parent/Guardian _____ Cell Phone _____

Home Address _____ Home Phone _____

Employer Name & Address _____ Work Phone _____

Please check which phone number should be first, second or third to reach you while your child is in the program.
Cell ☐1 ☐2 ☐3 Home ☐1 ☐2 ☐3 Work ☐1 ☐2 ☐3

Parent/Guardian _____ Cell Phone _____

Home Address _____ Home Phone _____

Employer Name & Address _____ Work Phone _____

Please check which phone number should be first, second or third to reach you while your child is in the program.
Cell ☐1 ☐2 ☐3 Home ☐1 ☐2 ☐3 Work ☐1 ☐2 ☐3

Please list two people not in the household to be contacted in the event of an emergency if the parent cannot be contacted.

Contact 1:

Name	
Street Address	
City	
State	Zip Code
Relationship to Child	
Home Phone	
Cell Phone	
Work Phone	

Contact 2:

Name	
Street Address	
City	
State	Zip Code
Relationship to Child	
Home Phone	
Cell Phone	
Work Phone	

Physician:

Name
Street Address
City, State, Zip Code
Phone

Dentist

Name
Street Address
City, State, Zip Code
Phone

PSR-3

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Annual Class Roster

Each year we prepare a roster for each group of children in our program.
This roster will not be furnished to any persons other than parents of children enrolled in our program.

I authorize the following to be listed on the parent roster: (Please check "Yes" or "No" in each column.)

My child's name	Parents'/Guardian's Name	Phone Number
☐ Yes ☐ No	☐ Yes ☐ No	☐ Work ☐ Mobile ☐ Home ☐ No

Signature of parent or guardian _____ Date _____

Chronic Physical Problem(s):
History of Hospitalization:
Diseases this child has had:
Allergies and Treatment:
Medications, Food Supplements, Modified Diet or Fluoride Supplements:

List of person(s) to whom child can be released (Please print)

List of person(s) NOT permitted to pick up this child (Please print)

	Restraint papers or divorce decree attached: ☐ Yes ☐ No
	Restraint papers or divorce decree attached: ☐ Yes ☐ No
	Restraint papers or divorce decree attached: ☐ Yes ☐ No

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Clark Early Learning Center Health History

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

School _____

Medical insurance: Primary _____ Secondary _____ ☐ None

Prenatal History

Birth Weight _____ lbs. _____ oz.
☐ Full Term ☐ Premature ☐ Late

Did you receive prenatal care during the
☐ 1st ☐ 2nd ☐ 3rd trimester

Mother's age at birth _____

Were drugs/alcohol used during pregnancy ☐ Yes ☐ No

Did baby require oxygen ☐ Yes ☐ No

Any feeding problems ☐ Yes ☐ No

Was infant breast-fed ☐ Yes ☐ No

Have jaundice ☐ Yes ☐ No

Birth defects/problems ☐ Yes ☐ No

If yes, please list

_____

_____

Does your child have any unusual birthmarks or blue spots? ☐ Yes ☐ No

Growth Development

What age did your child?
Crawl _____ Sit alone _____

Walk _____ Dress self _____

Speak with meaning _____

Stop using a bottle _____

Is your child toilet trained?
☐ Yes ☐ No If yes, at what age _____

Does child wear diapers or pull-ups?
☐ Yes ☐ No

How often does your child have toilet accidents? _____

Physician/Dentist

Physician/Clinic _____
Address _____
Phone _____
Dentist/Clinic Name _____
Address _____
Phone _____

Does child have any of the following?

Missing Teeth	☐ Yes	☐ No
Dental Caps	☐ Yes	☐ No
Loose Teeth	☐ Yes	☐ No
Cavities	☐ Yes	☐ No
Difficulty Eating	☐ Yes	☐ No
Other Dental Problems	☐ Yes	☐ No

Describe _____

How often does your child brush teeth?

_____

Health History

Has your child ever been seen by a dentist?

Has your child had any of the following?

Allergies	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Bleeding Tendencies	☐ Yes	☐ No
Bone/Joint Disorders	☐ Yes	☐ No
Broken Bones	☐ Yes	☐ No
Chicken Pox	☐ Yes	☐ No
Developmental Delays	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Ear Infections, 3 or more	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Hearing Difficulties	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Meningitis	☐ Yes	☐ No
MRSA	☐ Yes	☐ No
Nervous Habits	☐ Yes	☐ No
Over Weight	☐ Yes	☐ No
Phobias (Fears)	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Sickle Cell Trait	☐ Yes	☐ No
Skin Rashes/Infections	☐ Yes	☐ No
Speech Language Impairment	☐ Yes	☐ No
Tonsil Surgery	☐ Yes	☐ No
Trouble Sleeping	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Urinary Infections	☐ Yes	☐ No
Whooping Cough	☐ Yes	☐ No
Emotional Problems	☐ Yes	☐ No

If yes, explain _____

Exhibit destructive behavior ☐ Yes ☐ No
If yes, explain _____

Surgery/Hospital Stay ☐ Yes ☐ No
If yes, explain _____

Has your child ever had a serious accident - broken bones, head injuries falls and/or burns? ☐ Yes ☐ No
If yes, explain _____

List any diseases or conditions not listed:

_____

_____

Allergies (Identify)

Does your child have any allergies to the following?
Drugs _____
Plants/Animals _____

_____

Does your child take medication for allergies?

_____

Name of medications

_____

_____

_____

Taken how often _____

Nutrition History

Is your child on a special diet? ☐ Yes ☐ No
If yes, explain _____

_____

Does your child have any food allergies?
☐ Yes ☐ No If yes, explain _____

_____

Does your child eat any non-food items?
☐ Yes ☐ No If yes, explain _____

_____

Does your child take vitamins? ☐ Yes ☐ No
If yes, were they prescribed? ☐ Yes ☐ No
Does your child receive WIC? ☐ Yes ☐ No

Medication/Treatment

List medications taken daily or frequently

_____

_____

_____

_____

Taken how often _____

If your child received therapy, what type and where?

_____

_____

_____

Does your child use an EpiPen? ☐ Yes ☐ No

Other Information

Does your child have any of the following?

Glasses	☐ Yes	☐ No
Tubes in ear(s)	☐ Yes	☐ No

☐ Right ☐ Left ☐ Both

I understand that if my child has a medical or religious need for a special diet, I must submit the required form before my child may start.

Parent/Guardian _____ Date _____

Staff _____ Date _____

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Child Medical Statement

Required by Office of Early Learning and School Readiness

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

Height _____ Weight _____

Limitations or health condition (including allergies, medications, dietary restrictions)

Immunizations	Please check one
Complete for age	☐ Yes ☐ No
Immunizations	☐ Yes ☐ No

Exempt from Immunizations	Please check one
Religious conviction	☐ Yes ☐ No
Health concern	☐ Yes ☐ No
Other:	

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

Signature of examining Physician/Physicians Assistant or Advanced Practice Nurse Address: Phone:	Date of Exam

Required for children enrolled in an Early Childhood Education Grant Program or Preschool Special Education Program

Assessments/ Screenings	Type of Instrument Used	Date Completed	Pass or Fail	Referral Completed Yes or No
Vision			☐ Pass ☐ Fail	☐ Yes ☐ No
Hearing			☐ Pass ☐ Fail	☐ Yes ☐ No
Lead	☐ Yes ☐ No			
Hemoglobin	☐ Yes ☐ No			

PLEASE INCLUDE IMMUNIZATIONS

Student File Copy **Teacher File Copy**

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Clark Early Learning Center
Dental Form

Exam Date ____ /____ /_____

Child's Name _____ Birth Date ____ /____ /_____

Exam Completed by: ☐ DMD ☐ RDH ☐ Other: Specify _____

Provider Setting: ☐ Doctor/Dentist/Clinic ☐ School/Center ☐ Other: Specify _____

Evaluation Type: ☐ Screening ☐ Exam

Flossing Frequency: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Number of Times per Day Child Brushes Teeth: _____

Uses Fluoride Toothpaste: ☐ Yes ☐ No Takes Fluoride Supplement: ☐ Yes ☐ No

Gum Condition: ☐ Normal ☐ Swollen ☐ Bleeds Easily ☐ Infected

General Comments on Oral Health: _____

Today's Visit:
- ☐ Visual Screening
- ☐ Full Exam
- ☐ X-Rays
- ☐ Cleaning
- ☐ Fluoride Treatment
- ☐ Oral Hygiene Instruction
- ☐ Treatment (specify)

_____
_____
_____
_____
_____
_____

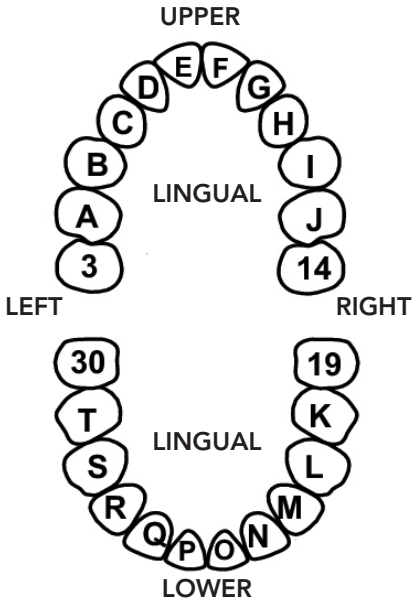
Treatment:
- ☐ No Needs
- ☐ Treatment Needed

Next Appointment Date:

____ /____ /_____

Treatment Plan:

_____
_____
_____
_____
_____
_____



Provider Signature _____ **Exam Completion Date** ____ /____ /_____

Printed/Stamped Name/Address of Provider: _____

Address _____ **Phone** _____

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Local Early Childhood Education Grant Eligibility Screening Tool Supplement

Child's Name _____

Section 1: Family Size: Check all that apply

- ☐ All parents/guardians of the child live in the home (including other siblings/children)
- ☐ A stepparent lives in the home including minor children
- ☐ Grandparents of the child live in the home; ONLY if parent of child is a minor
- ☐ Unmarried parents of any common child who lives in the home including minor children
- ☐ Child lives with foster or kinship family (must have custody papers)

Section 2: Income of the Family

- ☐ All adults are working outside of the home
- ☐ One of the adults is working outside of the home and another adult is not
- ☐ No one in the home is working - skip to Section 4
- ☐ Social Security Retirement

Section 3: Proof of Income: Check all that apply *(Documents must be attached)*

- ☐ I/we can provide 2 pay stubs (most recent)
- ☐ I/we can provide a W2 form
- ☐ I/we are self-employed AND can provide pay stubs or W2 (or can sign a release)
- ☐ I/we are self-employed and CANNOT provide pay stubs or W2
  - ☐ I can provide proof of estimated gross income based on current business records
- ☐ I/we PAY child support to someone else

Section 4: Parent/Guardian Proof of Unearned (other) income:

(even if there are workers in the home)

- ☐ O.W.F. Cash Assistance
- ☐ SSI
- ☐ Unemployment benefits
- ☐ Child Support
- ☐ SNAP Assistance (food stamps)
- ☐ Housing Assistance
- ☐ Utility Assistance (PIPP)
- ☐ I live rent free with someone who is not the biological parent of any of my children
- ☐ Shelter Living
- ☐ Food Pantry / Free Markets
- ☐ Soup Kitchen / Free Meals
- ☐ Clothing Closets
- ☐ Rides from Friends/Family Members
- ☐ Local Transit / Cab Vouchers
- ☐ Cash Gifts
- ☐ Gifts of groceries and personal items
- ☐ Other: _____

☐ I live with someone who is not the biological parent to my child/children but they provide for my living expenses.

Please have this person fill the bottom portion of this form out.

I, _____, cover the following expenses (circle those that apply):

housing, utilities, food, transportation for _____ and his/her family.

_____ _____

Signature Date

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Ohio Department of Job and Family Services Ohio Department of Education

Local Early Childhood Education Grant Eligibility Screening Tool Supplement

Child's Name _____

Tell us about you (the applicant)

First Name	MI	Last Name	
City			Today's Date
City	State	County	Zip Code
Phone Number	Additional Phone Number	Email Address	

Tell us about the people in your home

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

Tell us about your needs for your child(ren)

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

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

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

Tell us about your finances

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

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

If yes, please complete the table below.

Child's Name ______________________________

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

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

How much?

Signature of Applicant ______________________________ Date ______________

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Certification of Zero Income

Name _____

Address _____

Phone _____ Child's Name _____

I hereby certify that I do not receive income from any of the following sources

1. Wages from employment
2. Income from operation of a business
3. Rental Income
4. Interest or dividends from assets
5. Social Security payments, annuities, insurance policies, retirement funds, pensions or death benefits.
6. Unemployment or disability payments
7. Public assistance
8. Alimony, child support
9. Sales from self employment resources (Avon, Tupperware etc)
10. Any other source not named above

How do you pay for rent, utilities, food?

_____

_____

_____

_____

_____

Signature _____ Date _____