



South Central Local Schools
Home of the Trojans



Dear Parents,

This is the preschool application for the 2020-2021 school year. Please be sure to fill the preschool application out completely including the doctor and dentist's names and phone numbers on the Medical Emergency Form.

Below are a few requirements that you will need to know before returning the application.

- 1) A \$30.00 non-refundable supply fee will be due once your child is accepted into the preschool program. **Do not send any money with the application.** You will be billed for this at a later date.
- 2) Verification of Income **must** be sent with the application for **ALL** incomes in the household. Verification of income can be in the form of a pay stub, W-2, 1040 tax form, or medical card. **APPLICATIONS WILL NOT BE PROCESSED WITHOUT THIS INFORMATION.** Preschool tuition is based on a sliding fee schedule according to family size and income. Enrollment priority is given to income eligible families and children with an IEP. Income eligibility is based on the income earned and the total number of family members living in your home.
- 3) **The Medical/Physical Form and Dental Health Record must be turned in within 30 days of enrollment and every 13 months thereafter while your child attends preschool.** If these are not turned in within 30 days, your child will not be able to attend preschool. You can send the preschool application in before these forms are completed. If your child is returning to the preschool program for a second year, the Dental Health Record is not required.

This includes a medical statement and current list of immunizations. We hope your child has a regular medical provider from whom he/she receives ongoing medical care and follow-up. If your child does NOT have a regular medical provider, please inform your child's teacher so that we may assist, as appropriate, in helping you locate a local provider.

We have enclosed a copy of Lead Testing Requirements and Medical Management Recommendations per Ohio Department of Health. If your child has already been screened, please provide a copy of the results for your child's file as required for preschool licensing. If your child has NOT yet been screened as required, please discuss with your child's physician/health care provider the need to do so and forward results to our office. The purpose of this policy is to ensure the children's safety as much as possible.

- 4) Send copies of your child's shot record, certified birth certificate, and custody papers (if applicable). Returning students do not need to send this information unless custody has changed since the previous school year.
- 5) A Parent Handbook that contains all policies and procedures will be handed out before the first day of school.
- 6) Preschool screenings will be April 16th and 17th, 2020. Please contact Ms. Amanda Lynch at 419-752-3815 to immediately to schedule your preschool screening. Priority will be given to special education students, ECE grant students, and students who have completed a preschool screening. **Child must be screened before application will be accepted.**

Please return the application and all other documentation to:

South Central Board of Education
Attn: Preschool Application
3305 Greenwich-Angling Road
Greenwich, OH 44837

If you have any questions, please call Tyler Lauber at 419-752-3354 ext. 22249 between the hours of 9:00 a.m. – 3:00 p.m.

Sincerely,
Tyler Lauber, Director of Student Services
South Central Local Schools

PRESCHOOL APPLICATION
2020-2021 School Year

South Central Preschool Program
3305 Greenwich Angling Road
Greenwich, OH 44837
419-752-3815

For office use:
Date received: _____
Returning student: yes no

Please circle the preferred choice: **AM class** **PM class** (Class choice is not guaranteed.)

Child's Full Name _____
 Last First Middle (full middle name)

Child's nickname (name to be called in class) _____

Birthdate _____ Age _____ Male or Female (circle)

Address _____
 Street City Zip

City and State of child's birth _____

Parent(s)/Guardian(s) name _____

County of residence _____ School district _____

Home telephone _____ Emergency number _____

Father's employer _____ Phone number _____

Employer's address _____ Work schedule _____

Mother's employer _____ Phone number _____

Employer's address _____ Work schedule _____

List names of people authorized to pick your child up from school (must be over 18 years of age)

_____	_____
_____	_____
_____	_____

FAMILY INFORMATION

Names of others who reside in the home	Relationship to child
_____	_____
_____	_____
_____	_____

How long has your son/daughter attended school in the United States? _____

Interest Survey

Dear Families,

To help us understand and better communicate with your child, please take a few minutes to complete this Interest Survey. The information will help us be able to make your child feel more at ease at school. (And besides that, it's fun for us to read!)

Child's Name: _____

Nickname: _____ (Child's name as you want them to recognize it in print.)

Brother's/Sister's Name(s) and Ages: _____

Babysitter's Name: _____

Friend's Name(s): _____

Favorite Toy(s): _____

Favorite Food(s): _____

What does he/she call grandparents? _____

Any pets and their names: _____

What language does your son/daughter use most frequently at home? _____

What language do the adults at home most often speak? _____

Any other people, events, etc. your child especially likes/dislikes to talk about: _____

Is there anything of which your child is fearful? If so, what are some ways he/she is calmed?

What are your hopes for your child's preschool experience this year? (What is most important to you, such as experiences, opportunities, skills, etc.?) _____

What hobbies or special skills would you be willing to share? _____

VERIFICATION OF INCOME

Name of Child

Birthdate

Verification of current employment and salary is needed in order to determine the preschool program tuition for your child. List you or the people in your home receive income this month. 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, Worker's Compensation, Social Security, SSI, Veterans Benefits, etc.

Name	Type of Income	Amount of income (before taxes)	How often Received (weekly, bi-weekly, etc.)

Total yearly salary _____

Please attach one of the following for each family member receiving an income:

- _____ W-2
- _____ Check stub
- _____ Medical card
- _____ Other _____

Print name of parent/guardian

Social security number

Street address, City, Zip

Home phone number

Penalties for misrepresentation

I certify that all of the about information is true and correct and that all income is reported. I understand that this information is being given for receipt of state funds, that program officials may verify the information on the application, and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal criminal laws.

Signature of parent/guardian

Date

For Office Use

Signature of person verifying income

Date

CONSENT TO RELEASE CHILD'S PHOTO/VIDEO AND OTHER INFORMATION

To publicize the achievements of our preschool students and the great work they do, we like to occasionally publish our students' names, photos, and/or achievements in our school publications or release the information to local newspapers. We may also post the information on the school's website.

We understand that you may not want to have your child's name, photo, and/or achievements published. Please fill out this form to let us know your wishes.

School district South Central Local Schools Classroom teacher Michel Medrano

Student's name _____

- I consent to have my child's name, photo, and/or achievements published in school newspapers/newsletters, release to local newspapers, and posted on the school's website as it relates to activities and participation in the preschool program.
- I do not want my child's name, photo, and/or achievements published in school newspapers and/or newsletters, released to local newspapers or posted on the school's website.

Parent/Guardian Signature

Date

CONSENT FOR PARENT ROSTER

In accordance with Rule 3301-37-04 of the Ohio Revised Code, a roster for each classroom, which includes names, addresses and telephone numbers of parent(s)/guardian(s) of children attending the preschool program must be prepared annually and given to parents/guardians upon request, but to no other person.

_____ I would like my name and telephone number to be included in this roster.

_____ I would not like my name and telephone number to be included in this roster.

Parent/Guardian Signature

Date

CONSENT FOR FIELD TRIPS

_____ My child has permission to attend all school-sponsored field trips during the present school year. Written notice of each field trip will be sent home with your child.

Parent/Guardian Signature

Date

EMERGENCY/MEDICAL/TRANSPORTATION AUTHORIZATION FORM

Child's name _____ Grade _____ Telephone _____
Address _____
School district _____ Building _____

The purpose of this form is to enable parent(s)/guardian(s) to authorize the provision of emergency treatment for your child who becomes ill or injured while under school authority when you cannot be reached.

Residential parent(s)/guardian(s)

Mother/guardian name _____ Phone: Work _____ Home _____ Cell _____
Father/guardian name _____ Phone: Work _____ Home _____ Cell _____

Contact information if parents cannot be reached in case of emergency: **(2 contacts required)**

Name _____ Phone _____
Address _____ Cell _____

Name _____ Phone _____
Address _____ Cell _____

PART I OR PART II MUST BE COMPLETED

Part I: To Grant Consent

I hereby give consent for the following medical care providers and local hospital to be called.

Physician _____ Phone _____
Dentist _____ Phone _____
Medical specialist _____ Phone _____
Local hospital _____ Emergency room 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 above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my 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.

List all allergies and any special precautions or treatments indicated for these allergies. _____

List any medications, food supplements, modified diets, or fluoride supplements currently being administered to the child. _____

List any chronic physical problems and any history of hospitalizations. _____

List any diseases the child has had. _____

Has your child had chicken pox? _____

Signature of parent/guardian _____ Date _____

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 parent/guardian _____ Date _____

MEDICAL/PHYSICAL FORM

Child's Name _____ DOB _____ School _____
 Parent/Guardian Name _____ Phone _____
 Address _____

Required For Children Enrolled In An Early Childhood Education Grant Program Or Preschool Special Education Program			Reason Not Completed (Check Which Applies)		
Assessments/Screenings	Completed (Circle One)		Date Completed	Health Professional Decision	Examples: religious conviction, insurance coverage, other
Lead	Yes	No			
Hemoglobin	Yes	No			

PHYSICAL ASSESSMENT					
HEIGHT: _____			WEIGHT: _____		
Did the examination reveal any abnormalities in the following areas?					
	YES	NO		YES	NO
General Appearance	<input type="checkbox"/>	<input type="checkbox"/>		Heart/BP _____	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>		Lungs	<input type="checkbox"/>
Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>		Abdomen	<input type="checkbox"/>
Eyes/Vision	<input type="checkbox"/>	<input type="checkbox"/>		Genitalia	<input type="checkbox"/>
Ears/Hearing	<input type="checkbox"/>	<input type="checkbox"/>		Skeletal system	<input type="checkbox"/>
Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>		Neuro muscular	<input type="checkbox"/>
Teeth/Gums/Dental	<input type="checkbox"/>	<input type="checkbox"/>		Allergies	<input type="checkbox"/>
Tongue/Palate	<input type="checkbox"/>	<input type="checkbox"/>		Specify _____	<input type="checkbox"/>
Immunizations		Circle One			
Complete For Age	Yes	No			
In Process	Yes	No			
EXEMPT FROM IMMUNIZATIONS		Circle One			
Religious Conviction	Yes	No			
Health Concern	Yes	No			
Other:					
IMMUNIZATION RECORD MUST BE ATTACHED.					

Limitations or Health Condition (including allergies, medications, dietary restrictions) _____

This child has been examined and is in suitable condition to participate in group care.	
Signature of Examining Physician or Physician's Assistant or Advanced Practice Nurse (circle one) Address: _____ Phone: _____	Date of Exam

DENTAL HEALTH RECORD

Child's name _____ DOB _____ School _____
 Parent/guardian name _____ Phone _____
 Address _____

1. Has the child previously seen a dentist? No Yes Dentist's Name _____
2. Does the child have any trouble with teeth, gums, or mouth? No Yes
3. Oral condition before treatment: Missing Decayed Filled
4. Examination and treatment record

tooth letter	surface	description of work	date service performed	procedure number

8. Is baby bottle tooth decay present? No Yes
9. Is the child receiving: Topical Fluoride Application? No Yes
 Fluoride Supplement Diet? No Yes If yes, tablets ___ liquid ___
 Fluoridated water? No Yes
10. Is all planned treatment complete? No Yes If not, itemize on chart below.

tooth letter	surface	description of work

11. Approximate number of visits required for treatment? _____
12. Next scheduled appointment _____
13. Comments: _____

Dentist's Name _____
 Street Address _____
 City, State, Zip _____ Phone _____

Dentist's Signature _____ **Date of examination** _____