Tiny Toppers Integrated Preschool

Enrollment Form Checklist

Dear Families, Please ensure that you have completed each section on every form with no areas left blank or marked as N/A. Licensing laws in Ohio require that we have this information on file at all times. Please use the checklist below to ensure you have completed and returned all necessary paperwork. **Children will not be considered as registered until all of the required forms are returned.** The forms listed at the bottom of the page are not required at the time of registration but must be completed and returned prior to the first day of preschool. We appreciate your cooperation and support of your child's learning!

Forms Required for Complete Registration

_____ Preschool Registration Form

_____ Emergency Medical Authorization

_____ Family Information Form 01511

_____ Permission to Photograph

_____ Federal Poverty Information

_____ Home Language Survey

_____ Permission to Participate

_____ Annual Class Roster Participation Authorization

_____ Child Pick Up Authorization

_____ Proof of Residency and state identification card

_____ Immunization Record Form (**Required for registration, can be updated)**

_____ Copy of Original Birth Certificate

The following forms are required prior to the first day of preschool

_____ Medical Statement Form ***signed by a physician*** (Must be current at all times)

_____ Administration of Medication (if applicable)

For Office Use Only: Registration Fee: ____ Registration Complete: _____ Date:_____ Staff Initial: _____

Ohio Department of Education

Office of Early Learning and School Readiness

Preschool Registration Form

Revised 2/28/2019

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

Section I - Student & Family Information

Child's Name

First_____ Middle _____ Last _____

Family/Guardian Name _____

Home Address _____

City _____ State_____ Zip _____

Employer Name _____

Employer Street Address _____

Email Address _____

Birth City_____ Date of Birth _____

Please Indicate Call Order Using 1,2,3

Cell Phone _____ Call Order _____

Home Phone _____ Call Order _____

Work Phone _____ Call Order _____

City_____ State _____ Zip_____

Alternate Family Information:

Family/Guardian Name _____

Family Street Address _____

City _____ State _____ Zip _____

Employer Name _____

Employer Street Address _____

Email Address_____

Please Indicate Call Order Using 1,2,3

Cell Phone _____ Call Order _____

Home Phone _____ Call Order _____

Work Phone _____ Call Order _____

City _____ State _____ Zip _____

Section II - Authorization for Emergencies

List 2 Emergency Contacts for use ONLY if the parents cannot be contacted:

Name _____

Street Address _____

City_____ State_____ Zip _____

Please Indicate Call Order Using 1,2,3

Home _____ Call Order _____

Cell _____ Call Order _____

Work _____ Call Order _____

Name _____

Street Address_____

City _____ State _____ Zip_____

Please Indicate Call Order Using 1,2,3

Home_____ Call Order_____

Cell _____ Call Order_____

Work _____ Call Order _____

List Medical Contacts, In Case Of Emergency:

Physician _____

Street Address _____

City _____ State _____ Zip_____

Phone _____

Dentist_____

Street Address _____

City _____ State_____ Zip_____

Phone_____

Section III - Child's Health Information

Child's Chronic Medical/Health Needs

_____

_____

_____

_____

Child's History of Hospitalization:

_____
_____
_____

Child's Disease History:

_____
_____
_____

Child's Allergies/Treatment:

_____
_____
_____

Child's Dietary Needs/Restrictions:

_____
_____
_____

Child's Medication/s:

_____
_____
_____

NOTE: A MEDICATION FORM MUST BE COMPLETED FOR EACH MEDICATION ADMINISTERED WHILE IN PROGRAM ATTENDANCE

Section IV - Child's Sibling Information

Name_____ Age_____ Grade_____ School _____
Name_____ Age_____ Grade_____ School _____
Name_____ Age_____ Grade_____ School _____
Name_____ Age_____ Grade_____ School _____
Name_____ Age_____ Grade_____ School _____

Section V- Ethnicity and Race Information

Self Identification: Ideally a students ethnicity and race will be provided by the parents/guardian. It is the right of the parent/guardian to decline a statement of identification for a student. The district is required to fill in the ethnicity and race for every student. In cases where it is not provided the parent/guardian, the school will base their decision on available information including the student's home country, language spoken in the home and/or tribal affiliation.

_____I am choosing to decline

Ethnic Group Element: ____ White, Non-Hispanic _____ Black or African American (Non-Hispanic)_____ Hispanic Latino
____Asian _____ American Indian or Alaskan Native _____Multi Racial _____Native Hawaiian or Other Pacific Islander

Race Group Element: ____ White, Non-Hispanic _____ Black or African American (Non-Hispanic)_____ Hispanic Latino
____Asian _____ American Indian or Alaskan Native _____Multi Racial _____Native Hawaiian or Other Pacific Islander

Foster Child: Court Document must be provided Date Provided_____

Is this student a foster child:____ Yes _____No If yes, what agency is involved: _____

Agency caseworker name:_____ Phone: _____

Section VI - Registration Documents

Child immunization records attached: _____ Yes _____ No
Custody Journal Entry attached: _____ Yes _____ No
Birth Certificate attached: _____ Yes _____ No

Signature of Authorized Family Member/Guardian _____ Date_____

Chardon Local Schools Preschool Program
EMERGENCY MEDICAL AUTHORIZATION

Student Name _____

Address _____

Telephone _____

School Building _____

Teacher _____

Room # _____

Purpose – To enable parents/guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents/guardians cannot be reached.

PART I OR II MUST BE COMPLETED

PART I (GRANT CONSENT)

In the event that reasonable attempts to contact me at _____ (phone) or other parent/guardian _____ (name) at _____ (phone) have been unsuccessful, I hereby give consent for my child to be transported by emergency medical personnel to the nearest hospital or emergency treatment center. Preschool staff will make every attempt to notify my preferred physician/dentist listed on my child's medical statement.

This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity of such surgery, are obtained prior to the performance of such surgery.

Facts concerning child's medical history including allergies, medications taken, and physical impairments to which a physician should be alerted:

_____

_____

_____

Parent Signature _____ Date _____

DO NOT COMPLETE PART II IF YOU COMPLETE PART I

PART II (REFUSAL OF CONSENT)

I do not give 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 no action or to:

_____

_____

_____

Parent Signature _____ Date _____

Ohio Department of Job and Family Services

FAMILY INFORMATION
FOR STEP UP TO QUALITY PROGRAMS (SUTQ)

Child's Name *(Last)*	*(First)*	Nickname *(If any)*

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.

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? ☐ Yes or ☐ No Additional Details? (Center based, in home, with family, with parents, etc.)

My child drinks ☐ milk, ☐ formula, ☐ juice or ☐ 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

Tiny Toppers Integrated Preschool
Chardon Local Schools
308 Maple Ave.
Chardon, Ohio 44024

Permission to Photograph

Student's Name _____

I, _____, give permission for the Tiny Toppers Integrated Preschool
(Parent/Guardian's Name)
staff to photograph my child, _____, for the following purposes:
(Child's Name)

Type of Use	Yes, I grant permission	No, I do not grant permission
My child's name can be included for distribution to classmate's families.	Yes	No
My child's name may be used in press releases, newspapers, slides, or social media accounts such as Preschool Facebook and Twitter.	Yes	No
My child's photo may be used for classroom purposes.	Yes	No
My child's photo may be used in press releases, brochures, newspapers, slides, videotapes or still pictures to educate others about the Tiny Toppers Preschool or to demonstrate teaching techniques.	Yes	No
My child's photo may be used on the Tiny Toppers Preschool social media accounts such as Facebook and Twitter or on the Chardon Local Schools website.	Yes	No

** Only first names and possibly last initials (in the event there are two children with the same first name) will be displayed on any print or digital media.

I understand that it is my responsibility to update this form in the event I do not wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

_____ _____
Signature of the parent/guardian Date

Preschool Federal Poverty Form

Every year we are required by the Ohio Department of Education to report income levels for families of ALL students enrolled in ODE licensed preschool programs. Below are the 2019 Poverty Guidelines published by the US Department of Health and Human Services. Please circle the appropriate family size and income level for your household.

Office of Early Learning and School Readiness

United States Department of Health and Human Services
2019 FEDERAL POVERTY GUIDELINES

Size of Family Unit	100% Poverty Level	125% Poverty Level	150% Poverty Level	175% Poverty Level	185% Poverty Level	200% Poverty Level
1	$12,490	$15,613	$18,735	$21,858	$23,107	$24,980
2	$16,910	$21,138	$25,365	$29,593	$31,284	$33,820
3	$21,330	$26,663	$31,995	$37,328	$39,461	$42,660
4	$25,750	$32,188	$38,625	$45,063	$47,638	$51,500
5	$30,170	$37,713	$45,255	$52,798	$55,815	$60,340
6	$34,590	$43,238	$51,885	$60,533	$63,992	$69,180
7	$39,010	$48,763	$58,515	$68,268	$72,169	$78,020
8	$43,430	$54,288	$65,145	$76,003	$80,346	$86,860
Family units with more than 8 members	Add $4,420 for each additional	Add $5,525 for each additional	Add $6,630 for each additional	Add $7,735 for each additional	Add $8,177 for each additional	Add $8,840 for each additional

200% of Federal Poverty Level Income Chart

Household Size		Annual Income
1	(income less than)	$24,980
2		$33,820
3		$42,660
4		$51,500
5		$60,340
6		$69,180
7		$78,020
8		$86,860

For each additional family member, add $8,840 at the 200% level.

____ At this time, we are refusing to provide this information. ___ More than 200%

Please note that these are annual amounts. *If your household brings in more than the amount in the 200% column, please check the box indicating such.* We do not need to know the amount. You may choose to complete the form as listed above or check the refuse to answer. Either way we must have this form on file.

Student Name_____

Parent/Guardian Signature _____ Date: _____

Parent Guardian Print _____

Ohio | Department of Education

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? ☐ Yes ☐ 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? ☐ Yes ☐ 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

Ohio | Department of Education

(Appendix A, continued)

*****COMPLETED BY SCHOOL EMPLOYEE*****

1. **Check.** Confirm the following statements related to the administration of Ohio's language usage survey:

   ☐ The district or school presented the language usage survey, to the extent practicable, in a language and form that the parent or guardian understood.

   ☐ The district or school informed the parent(s) or guardian(s) of the form's purpose. The language usage survey only is used to understand students' linguistic experiences and educational background.

   ☐ The district or school reports information from the language usage survey in the appropriate Educational Management Information System (EMIS) records.

   ☐ For students enrolling from other U.S. schools and districts, school officials request previous language survey data and refer to the information when identifying English learners.

   ☐ Results of the language usage survey are kept with the student's cumulative records and follow the student if he/she transfers to another district or school.

2. **Note.** Record additional information to assist the review of the language usage survey.

3. **Record.** Indicate responses from the language usage survey in the table below. Refer to the Language Usage Survey Annotations on page 2 for item-specific guidance.

Student's native language See Language Usage Survey Question 2. Report for all students in EMIS.	_____
Student's home language See Language Usage Survey Question 3. Report only for English learners in EMIS.	_____
Potential English learner See Language Usage Survey Questions 2-4.	☐ Yes. Assess the student's English proficiency. ☐ No. Do not assess the student's English proficiency.
Immigrant student status See Language Usage Survey Questions 5-7. Report for all students in EMIS.	☐ Yes, the student is an immigrant child. ☐ No, the child is not an immigrant child.

4. **Validate.** Complete the information below.

_____ _____
Signature of validating school employee Date (mm/dd/yyyy)

_____ _____
Printed name of validating school employee Name of school or school district

Tiny Toppers Integrated Preschool
Chardon Local Schools
308 Maple Ave.
Chardon, Ohio 44024

Permission for Participation

Student's Name _____

1. My Child has permission to participate in health screenings that are scheduled through the school district and various community agencies

Name of Screening	Yes, I give permission	No, I do not give permission
Vision	Yes	No
Hearing	Yes	No
Height	Yes	No
Weight	Yes	No
Social Emotional	Yes	No

2. I will be responsible for assisting in obtaining follow-up care for my child if the need arises based on results from any health/developmental screenings or assessments performed that identify an area of concern.

3. I understand that there may be some screenings that are not able to be conducted through my child's educational preschool program and I may need to obtain these screenings through my child's doctor, dentist, local health department or other community agency that is able to perform the needed screening.

4. The Tiny Toppers Integrated Preschool has my permission to conduct developmental assessments, which may include but are not limited to Early Learning Assessment (required by Ohio Department of Education) and the AEPS, a preschool curriculum assessment. Once the assessment has been completed, the teacher will provide feedback regarding the assessment at conferences.

Yes, I give permission	No, I do not give permission
Yes	No

By signing this form, I verify that I have read this form and have indicated my preferences for screenings. I also agree to comply with the above regulations to the best of my ability.

_____ _____

Signature of the parent/guardian Date

308 Maple Ave
Chardon, Ohio 44023
440-285-4066

Annual Class Roster Participation Authorization

Each year the program prepares a class/program roster of children enrolled in the program. This roster will not be furnished to any other person other than parents of children enrolled in the program.

I authorize the following to be listed on the preschool roster:

My Child's Name _____ Yes _____ No

Family Name _____ Yes _____ No

Phone Number _____ Yes _____ No

Parent Signature: _____

Date: _____

Child Pick Up Authorization

Childs name_____ Child's date of birth_____

Parents, please complete information below. For the safety of your children we allow only the people listed below to pick-up your child.

Authorized Name	Relationship	Phone Number

Person(s) **NOT AUTHORIZED** to pick up my child (legal documentation is required to limit a parent's access to his/her child)

NOT Authorized Name	Relationship

Include any additional information or comments below.

_____

_____

_____

_____

_____

Parent/Guardian signature _____ Date_____

Ohio | 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	○ Yes ○ No	Religious Conviction	○ Yes ○ No
In Process	○ Yes ○ No	Health	○ Yes ○ 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.

CHARDON LOCAL SCHOOLS
MEDICATION PERMISSION FORM

Student Name:_____ Grade/Class _____ Teacher:_____ School _____
Student Address:_____ Date of Birth_____

TO BE COMPLETED BY HEALTH CARE PROVIDER *Please print clearly and complete **ALL sections.***

Name of Medication	Dose	Route (circle)	Time/Frequency (Include minimum time Interval for prn dosing)	Reason for Medication	Start Date	Stop Date	Adverse Reaction to Report to Physician and/or Special Instructions
		Tablet/Capsule PO Liquid PO Inhaler/Nebulizer Other_____	_____ **OR** As needed every __hrs.		__/__/__	___/___/___ **OR** ___ End of School year	
		Tablet/Capsule PO Liquid PO Inhaler/Nebulizer Other_____	_____ **OR** As needed every __hrs		__/__/__	___/___/___ **OR** ___ End of School year	

EPINEPHRINE AUTOINJECTOR SELF-CARRY AUTHORIZATION	☐ **Not Applicable** ☐ **Yes, as the prescriber I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.**
ASTHMA INHALER SELF-CARRY AUTHORIZATION	☐ **Not Applicable** ☐ **Yes, as the prescriber I have determined that this student to capable of possessing and using this inhaler appropriately and have provided the student with training in the proper use of the inhaler.**

Reminder note for prescriber: ORC 3313.718 requires backup epinephrine autoinjector and best practice recommends backup asthma inhaler

Health Care Provider Name _____ Health Care Provider Signature: _____
Date_____ Phone Number: _____ Fax Number: _____

TO BE COMPLETED BY PARENT OR GUARDIAN

☒ **I** authorize an employee of the school board to administer the above medication. ☒ I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. ☒ I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order. ☒ Medication form must be received by the principal, his/her designee, and/or the school nurse. ☒ I understand that the medication must be in the **original** container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.

CHECK BELOW ONLY IF PHYSICIAN HAS GIVEN AUTHORIZATION TO SELF-CARRY EPINEPHRINE AUTOINJECTOR OR INHALER.

☐ *For Epinephrine Autoinjector: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.*

☐ *For Asthma inhaler: As the parent/guardian of this student, I authorize my child to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.*

Parent/Guardian Name_____Parent/Guardian Signature_____Date_____Phone_____